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GLOSSARY OF ACRONYMS

ABD	Aid to the Blind and Disabled
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
AR	Authorized Representative
ARC	AIDS Related Complex
CCR	California Code of Regulations (Title 22)
CFR	Code of Federal Regulations
CWD	County Welfare Department
CWDL	County Welfare Directors Letter
DC	Disabled Child
DEA	Disability Evaluation Analyst
DED	Disability Evaluation Division
DHS	Department of Health Services
DOB	Date of Birth
DOT	Dictionary of Occupational Titles
DSS	Department of Social Services
EW	Eligibility Worker
FP-DED	Federal Programs-Disability Evaluation Division
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
IHSS	In-Home Supportive Services
IRCA	Immigration Reform and Control Act
IRWE	Impairment-Related Work Expenses
LASPB	Los Angeles State Programs Branch
MC	Medi-Cal
MC	Medical Consultant
MCIN	Medi-Cal Information Notice
MEB	Medi-Cal Eligibility Branch
MEPM	Medi-Cal Eligibility Procedures Manual
NOA	Notice of Action
OBRA	Omnibus Budget Reconciliation Act
OSPB	Oakland State Programs Branch
PD	Presumptive Disability
RRB	Railroad Retirement Board
RSDI	Retirement, Survivors and Disability Insurance (Title II)
SAWS	Statewide Automated Welfare System
SDI	State Disability Insurance
SGA	Substantial Gainful Activity
SOC	Share of Cost
SP-DED	State Programs-Disability Evaluation Division
SSA	Social Security Administration
SSI/SSP	Supplemental Security Income/State Supplementary Program (Title XVI)
SSN	Social Security Number
UWA	Unsuccessful Work Attempt
VA	Veterans Administration
VR	Vocational Rehabilitation
WC	Workers' Compensation

22A – INTRODUCTION TO THE DISABILITY PROGRAM

Methods for confirming disability are listed in the California Code of Regulations, Title 22, Section 50167(a)(1), (A) through (B). The following describes disability requirements for federal disability under Social Security and state disability under Medi-Cal.

1. FEDERAL DISABILITY REQUIREMENTS (Title 22, Section 50223)

A. ADULTS

Federal law defines a person 18 years or older as disabled if the Social Security Administration's (SSA's) disability criteria for Title II, Retirement, Survivors and Disability Insurance (RSDI), or Title XVI, Supplemental Security Income (SSI), are met.

Title II (RSDI) Benefits — SSA administers monthly payments to aged, blind and disabled persons who have previously worked and have sufficient work quarters.

Title XVI (SSI) Benefits — SSA administers monthly payments to aged, blind and disabled (ABD) persons whose income and resources are below certain limits.

B. CHILDREN

Children under 18 years old are disabled if they have a medically determinable physical or mental impairment which meets the SSI Disabled Child criteria.

C. SSA DEFINITIONS

Disability — Federal law defines disability as "the inability to engage in any Substantial Gainful Activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months".

Substantial Gainful Activity (SGA) — SGA means work that (a) involves doing significant and productive physical or mental duties; and (b) is done, or intended, for pay or profit.

2. STATE DISABILITY REQUIREMENTS (Title 22, Sections 50203 and 50223)

State law requires that Medi-Cal clients, aged 21 to 64 who allege disability, have their eligibility evaluated under the Aged, Blind, and Disabled-Medically Needy (ABD-MN), Title XIX program. The SSA disability criteria for Title II/Title XVI are used to evaluate disability for ABD-MN.

The disability evaluation process also applies to clients who are eligible and linked to other programs (Aid to Families with Dependent Children-Medically Needy, Medically Indigent Children, etc.), who allege disability and who choose to go through this process.

The ABD-MN program is 50 percent federally funded and allows clients to have greater income deductions which may lower or eliminate their Share of Cost (SOC).

3. OTHER DISABILITY PROGRAMS

Disability established under other programs such as State Disability Insurance (SDI), Veterans' Benefits, Workers' Compensation, etc., DOES NOT establish disability for Medi-Cal. Recipients of such benefits who apply for Medi-Cal disability, who meet income and resource requirements, must have their claim sent to SP-DED for a disability decision.

22B – AGENCIES INVOLVED IN THE DISABILITY EVALUATION PROCESS

The roles of various government agencies involved in the disability evaluation process are provided below.

1. SOCIAL SECURITY ADMINISTRATION (SSA) AND FEDERAL PROGRAMS - DISABILITY EVALUATION DIVISION (FP-DED)

The Social Security Administration (SSA) contracts with the Disability Evaluation Division (DED) of the state Department of Social Services to perform medical determinations of disability. There are two components of DED: Federal Programs (FP) Branches determine disability for SSA's Title II program and Title XVI, the Supplemental Security Income (SSI) program and State Programs (SP) Branches determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI.

Disability Evaluation Analysts in Federal Programs-DED (FP-DED) are responsible for obtaining medical and vocational documentation, ordering consultative examinations, evaluating medical evidence and work and/or social history, and making a disability determination along with a Medical Consultant.

2. HEALTH CARE FINANCING ADMINISTRATION (HCFA)

HCFA administers the Medicaid program and sets forth the federal regulations for its implementation. HCFA has designated the state Department of Health Services (DHS) to oversee the Medicaid program (Medi-Cal) in California.

3. STATE DEPARTMENT OF HEALTH SERVICES (DHS)

DHS is responsible for implementing federal regulations, developing policies and procedures, and providing guidance to ensure compliance with regulations. DHS contracts with State Programs-DED (SP-DED) to do disability evaluations for those applying for Medi-Cal as a blind or disabled person.

DHS works with county welfare departments (CWDs) to ensure that Medi-Cal applications based on disability are processed timely between SP-DED and CWDs.

4. STATE PROGRAMS-DED (SP-DED)

The State Programs-DED located in Los Angeles and Oakland determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI. SP-DED does disability evaluations for clients applying at CWD for the Aged, Blind and Disabled-Medically Needy (ABD-MN) program. Disability criteria are the same for federal and state DED staff. Upon completion of the disability evaluation of a blind or disabled client, the CWD is advised of the decision so that the Medi-Cal claim processing may be completed.

5. COUNTY WELFARE DEPARTMENT (CWD)

Whereas SP-DED is responsible for the medical determination of disability, the CWD is responsible for the non-medical portion of determining eligibility for Medi-Cal disability.

The following steps should be followed by CWDs when a Medi-Cal client claims to be disabled or blind, either verbally or in writing, such as in the Statement of Facts (MC 210), Status Report (MC 176S), or a letter:

Document	In case record how disability was evaluated.
Confirm	Disability, using methods listed in Title 22, Section 50167(a)(1); (a) through (c).
Refer	Client to SSA or SP-DED if disability is not confirmed by methods listed in Title 22, Section 50167 (a) (1), (a) through (c).
Review	MC 223 to decide if a prior disability decision was made by SSA. If yes, responsibility for a current evaluation **may** belong to SSA and client may be referred back to SSA. An MC Information Notice 13 and a denial notice of action (NOA), if applicable, must be provided to client to take to SSA.

22C – COUNTY WELFARE DEPARTMENT PROCEDURES

This section lists the various activities the County Welfare Department (CWD) performs in processing claims for Medi-Cal disability. The major CWD activities are listed in separate sections (22 C-1 to C-9) which provide a more comprehensive discussion and instructions for implementation.

C-1.	***Referring Disability Applications To SSA Or SP-DED***	Specifies circumstances in which disability applications are referred to SSA or accepted by CWD for referral to SP-DED.
C-2.	***Determining Substantial Gainful Activity (SGA)***	Provides criteria and instructions on processing claims when applicants are working and engaging in SGA.
C-3.	***Determining Presumptive Disability (PD)***	Provides criteria and procedures for determining if a client can granted PD. Includes detailed criteria for clients with Human Immunodeficiency Virus (HIV) infection.
C-4.	***Completing Disability Evaluation Forms***	Provides a list of forms used in the disability evaluation process. Includes instructions on the use of the forms.
C-5.	***Providing CWD Worker Observations***	Provides background on the importance of CWD observations and how they can be provided to SP-DED. Includes a form which can be used to provide observations to SP-DED.
C-6.	***Assembling And Sending SP-DED Packets***	Discusses limited and full packet situations, retroactive Medi-Cal requests, prior SSI/SSP recipients, and Railroad Retirement Board disability claims.
C-7.	***Communicating With SP-DED And DHS About Changes And Status***	Provides instructions for notifying SP-DED about changes which occur during claim development and use of status information reports provided by SP-DED. Discusses methods to communicate with DHS.
C-8.	***Processing SP-DED Decisions***	Provides information on allowance, denial and no determination decisions. Includes instructions on CWD actions to be taken upon receipt of SP-DED's decision.
C-9.	***Processing Reexaminations, Redeterminations And Reevaluations***	Provides criteria and instructions on how reexaminations, redeterminations and reevaluations should be processed.

22 C-1 -- REFERRING DISABILITY APPLICATIONS TO SSA OR SP-DED

1. BACKGROUND

The 1990 revisions to CFR 435.541 specify the situations when client must be referred back to the Social Security Administration (SSA) to apply for disability benefits, or be allowed to file a Medi-Cal application based on disability. Therefore, it is very important that CWDs carefully review the MC 223 (Applicant's Supplemental Statement of Facts for Medi-Cal) to determine who has jurisdiction over an application for disability benefits.

NOTE: A chart at the end of this section identifies situations when a client is referred to SSA or SP-DED after/during SSA's decision on a disability claim.

When a Medi-Cal application based on disability is accepted from client, optional form MC 017/MC 017 (Sp) may be given to client. This informational form gives client an overview of what can be expected when a disability application is filed.

2. FEDERAL DISABILITY EVALUATION BY SSA

A. Guidelines For Referring Client To SSA

SSA refers case to FP-DED for a disability evaluation in the following situations. (Refer to SSA/SP-DED chart at the end of this section to determine when to refer client to SSA.)

SSA Has Denied Disability Status Within The Previous 60 Days	Client must ask SSA to "reconsider" a previous denial action, as client has 60 days to appeal SSA's decision. CWD will deny the Medi-Cal application. If client has a reconsideration request pending with SSA, CWD will deny the Medi-Cal application.
SSA Has Denied Disability Status More Than 60 days But Within One Year Of Current Date	1. Client must ask SSA to "reopen" the previous evaluation. At its discretion, SSA may or may not "reopen" the claim. CWD will deny the Medi-Cal application. 2. If client's same condition has changed or worsened, CWD must refer client back to SSA. CWD will deny the Medi-Cal application.

3. If SSA denied the disability claim after reopening the previous decision, SSA's decision would be controlling over Medi-Cal. CWD will deny the Medi-Cal application.

SSA Denied Claim More Than One Year Before The Current Date

If client does not allege that the same condition has worsened OR that there is a new condition, client will be asked to file a new application with SSA. CWD will deny the Medi-Cal application.

B. Special Handling of Federal Decisions

The following specifies situations when CWD can rescind a prior Medi-Cal denial, after following the 1990 Regulations which require that a Medi-Cal application be denied and client referred back to SSA.

SSA Approves Disability After Originally Denying Claim

CWD will RESCIND prior Medi-Cal denial and approve Medi-Cal, if otherwise eligible. New application or referral to SP-DED not needed if SSA's disability onset date coincides with request for Medi-Cal coverage.

If retro Medi-Cal is needed, send full packet. Include SSA award letter. In item 5 of MC 221, indicate initial Medi-Cal application date (before client was referred to SSA) to protect client's original filing date and specify "client was originally denied and referred to SSA for reopening" in Item 10 (Comments section) of MC 221.

NOTE: Request for retro onset must be made within one year of the month for which retroactive coverage is requested.

3. STATE DISABILITY EVALUATION BY SP-DED FOR MEDI-CAL

The following are guidelines for determining who should and should not be referred to SP-DED for a Medi-Cal disability evaluation. (Refer to SSA/ SP-DED chart at the end of this section to determine when to refer claim to SP-DED after/during SSA's decision on a disability claim.)

A. Who Should NOT Be Referred To SP-DED

Incapacity Or Pregnancy Verification	Do not refer clients to request verification of incapacity or pregnancy
Prior SP-DED Decision - Disabled	Do not refer client who has had a decision made within the past 12 months unless the reexamination date has passed, or there is an indication that the medical condition has improved.
Prior SP-DED Decision - Not Disabled	Do not refer client who has had a claim denied within the past 90 days. Client should be advised of the appeal process. However, if CWD believes that the SP-DED denial is incorrect, the case may be sent back for a reevaluation within 90 days, as discussed in C-9.
Other Factors Causing Ineligibility	Do not refer client who CLEARLY does not meet other eligibility factors, such as state residence or resource limits, or if there are questions about other verifications. Otherwise, if DED packet is complete, send it while other eligibility factors are being verified.
Refusal To Be Evaluated	Do not refer client who refuses to be evaluated, as any client has the right to refuse to be evaluated for a disability. CWD should discuss the possibility of a disability referral with clients who appear to be disabled but who have not requested a disability evaluation. *Example: Client is confined to a wheelchair, or has difficulty walking, standing or sitting; the individual seems disoriented, or shows extreme emotional distress.*
Prior SSA Decision-Not Disabled	Do not refer clients to SP-DED who were denied disability status by SSA: 1. Within 60 days: refer to SSA for a reconsideration.

2. Within 12 months: client alleges same condition worsened; does not allege a new condition; did not ask SSA to reopen claim.

3. More than one year ago: client does not allege the same condition has worsened or that there is a new condition.

4. At any time: when client appealed denial and decision on appealed claim is pending.

B. Who SHOULD BE Referred To SP-DED

No Prior SSA Evaluation	Client's disability has never been evaluated by SSA.
SSA Application Status Is Unknown Or Pending	Client's application for RSDI (Title II) or SSI (Title XVI) is pending or client does not know status of claim.
SSA Application Denied Because of Excess Income/Resources	Client's application for SSI is denied for excess income/resources and client has proof of such, and client meets income/resource requirements for Medi-Cal.
SSA Approved Claim	SSA has set a specific onset date as the start of disability, and client is requesting retroactive Medi-Cal coverage prior to that onset date.
SSA Denied Claim	1. SSA denied claim within 12 months, alleges new condition not considered by SSA, has not reapplied with SSA. 2. SSA denied claim over 12 months ago, same condition worsened, has not reapplied with SSA. 3. SSA denied claim over 12 months ago, has new condition not considered by SSA, has not reapplied with SSA.

SSA Discontinued Claim	SSA discontinued SSI benefits for reasons other than disability and client still has the medical condition which was the basis for the SSI decision.
SSA Refuses To Reopen Claim	SSA, at its discretion, refuses to accept a reopening request, and client returns to apply for Medi-Cal disability.
Railroad Retirement Board (RRB) Disability	RRB determined Occupational Disability only.
Medi-Cal Denied Claim	Client was denied Disabled-MN benefits for failure to cooperate with SP-DED and good cause is established.
Former SSI Recipient, 65 Years Or Older	An evaluation for former blind SSI/SSP recipients may be necessary even if client reached age 65 or has already been determined disabled. Under the Pickle Amendment to the Social Security Act, blind individuals are entitled to a higher SSI/SSP payment level than disabled or aged persons. Indicate "Pickle Person" on the MC 221 under "Type of Referral" or packet may be rejected as unnecessary.
In-Home Supportive Services (IHSS)	An applicant for IHSS who is NOT receiving SSI must have an independent evaluation of disability performed by SP-DED.
Omnibus Budget Reconciliation Act (OBRA)	OBRA provides restricted Medi-Cal benefits to otherwise eligible aliens who are not in a satisfactory immigration status.

SSA/SP-DED CLIENT REFERRAL CHART

Items 5 to 5D of the MC 223, Applicant's Supplemental Statement of Facts For Medi-Cal, identify whether client has applied for Social Security or SSI disability benefits in the past two years. Client's responses determine whether a disability claim is referred to SSA or SP-DED. The following chart helps to identify where the claim should be referred.

CLIENT STATUS	SITUATION	QUESTIONS AND ANSWERS	SSA	SP-DED
1. Did Not Apply		Q 5 = No		X
2. Applied	Application Status Unknown or Pending	Q 5 = Yes Q 5A = Unknown/Pending		X
3. Allowed/Denied	Decision On Appeal	Q 5 = Yes Q 5A = On Appeal	X	
4. Allowed	Has SSA award letter proving current receipt of benefits.	Q 5A = Approved	None	None
5. Allowed	Has SSA award letter proving current receipt of benefits. Needs retro Medi-Cal.	Q 5A = Approved		X
6. Denied	Has SSA letter proving denial based on income and/or resources.	Q 5A = Denied		X
7. Denied	Denial within previous 60 days. Did not ask SSA to reconsider the previous denial.	Q 5B = Date within 60 days.	X	
8. Denied	Denial within 12 months. Alleges worsening of same condition. (Provides proof, if condition now meets Presumptive Disability criteria.) Did not ask SSA to reopen previous denial.	Q 5B = Date within 12 months. Q 5C = Yes	X	
9. Denied	Denial within 12 months. Has SSA letter proving SSA refusal to reopen previous denial.	Q 5B = Date within 12 months.		X
10. Denied	Denial within 12 months. Alleges new condition not considered by SSA. Has not reapplied with SSA.	Q 5B = Date within 12 months. Q 5D = Yes		X
11. Denied	Denial within 12 months. Does not allege new condition or worsening of same condition.	Q 5B = Date within 12 months. Q 5C/D = No	X	
12. Denied	Denial over 12 months. Same condition worsened, or has new medical problem not considered by SSA. Has not reapplied or appealed with SSA.	Q 5B = Date over 12 months. Q 5C/D = Yes		X
13. Denied	Denial over 12 months. No worsening of same condition, or has no new medical problems.	Q 5B = Date over 12 months. Q 5C/D = No	X	

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22 C-2 -- DETERMINING SUBSTANTIAL GAINFUL ACTIVITY

1. BACKGROUND

Section 435 540 of 42 Code of Federal Regulations (CFR) requires Medi-Cal to use the Supplemental Security Income (SSI) definition of disability to decide whether a client is eligible for Medi-Cal based on disability.

To be considered disabled, SSI requires that an individual be.

"unable to engage in Substantial Gainful Activity (SGA), due to a medically determined physical or mental impairment, which is expected to result in death, or which is expected to last for a continuous period of 12 months"

A client who performs SGA is not disabled, even if a severe physical or mental impairment exists

2. THE CURRENT SGA AMOUNT

Since the SGA amount is now based on the federal average wage index, the dollar amount may be adjusted annually

- Using the new formula, the SGA amount has increased to $830 per month effective January 1, 2005.

NOTE Since the SGA amount may change annually, future revisions to the manual regarding the actual SGA amount will only be reflected in this section All other references to the SGA amount will only state "Current SGA Amount" and no dollar figure will be noted

3. WHEN TO USE THESE PROCEDURES

These procedures will be used when a client

- files for Medi-Cal disability, states on the MC 223 that he or she is working, and has gross earnings of more than the current SGA amount per month, or

- meets the criteria for Presumptive Disability (PD) but earns over the current SGA amount per month, PD should not be approved until an SGA determination is made (except as indicated in the "notes below)

NOTE. Individuals applying for or enrolled in the 250 Percent Working Disabled (WD) program must meet the SSI federal definition of disability except that they may engage in SGA. When submitting disability packets to State Programs-Disability and Adult Programs Division (SP-DAPD), the MC 221 (Disability Transmittal Form) must indicate that the case is a 250 Percent WD case. For additional information regarding the 250 Percent WD program, see Section 5R of this manual

NOTE These procedures do not apply to clients who are blind, or to beneficiaries who return to work after disability has been approved If an SGA evaluation was not performed because the client alleged blindness and SP- DAPD found that the client was disabled but not blind, an SGA evaluation must be performed before eligibility as a disabled person can be established

4. PROCEDURES

A SGA DETERMINATIONS

The EW shall determine whether a client is performing SGA when a client has earned income over the current SGA amount per month. The EW shall:

1 Obtain Client's gross monthly earnings (if irregular, earnings should be averaged). Earnings derived from In-Home Supportive Services are treated as earned income

2 Determine Whether there are impairment-related work expenses (IRWEs) or subsidies that can reduce earnings below the SGA amount (IRWEs and Subsidies are discussed further in this section)

3. Deny Medi-Cal disability application if "net countable earnings" are over the current SGA amount

4. Submit: A full disability packet to SP-DAPD, including an MC 220, MC 221,and MC 223, only if "net countable earnings" do not exceed the current SGA amount

5 Alert Is sent to SP-DAPD via a DAPD Pending Information Update Form (MC 222) when a disability packet was sent to SP-DAPD and the client is subsequently found to be engaging in SGA SP-DAPD will stop case development and return case to county of origin

Work Activity Report Form (MC 273, Exhibit 2) should be provided to client whose earnings are over the current SGA amount to help in making SGA determinations.

B. IMPAIRMENT-RELATED WORK EXPENSES

Impairment-related work expenses (IRWEs) are certain expenses that are incurred and paid by an impaired client to enable him/her to work

1. SGA Determination

IRWEs can be deducted from gross earnings to arrive at "net countable earnings"

If "net countable earnings" are over the current SGA amount, deny the application. For self-employment, IRWEs can be deducted from net income, if not already deducted from gross income as a business expense.

Example The current SGA amount is $830 The client earns $1,100 per month and has $200 worth of IRWEs for special transportation costs to go to work and for medications needed to control a seizure disorder In this example the "net countable earnings" are $900 per month ($1100-200) As "net countable earnings" ($900) are more than the current SGA amount, the client is performing SGA and the application is denied

Do NOT apply ABD-MN or AFDC MN/MI earned income deductions when determining SGA.

2. Allowable IRWE Deductions

Deductions are allowed when the following conditions exist:

a. Disabled client needs the item/service in order to work. The need must be verified by the prescribing source (e.g., doctor, Vocational Rehabilitation [VR]). The cost must also be verified.

b. Cost is paid by disabled client and not reimbursed by another source (e.g., Medicare, VR). The cost must be paid in cash, including checks or money orders, and not in kind.

c. Expense is "reasonable". It represents comparable charges for the item/service in the community. Sources such as a medical supplier or VR may be contacted.

Example: Client states he/she needs an attendant to assist in activities to prepare for work. Client has a family member perform the services and is charged $15 per hour. If Personal Care Services provided through In-Home Supportive Services allows a payment of $4.25 per hour, only $4.25 per hour should be allowed as a deduction.

3. Budgeting of IRWE

Payment must be made after client became disabled in order for cost to be deducted. Payment is computed in the following ways:

a. Recurring and Non-Recurring IRWEs

1. Recurring costs, such as monthly payments for a wheelchair: the amount paid monthly is deductible.

2. Non-recurring down payments, or full purchase price paid for an item: a lump sum payment may be prorated over 12 months.

b. Cost Incurred Before or After Work

1. Before work started: Prorate the cost over a 12-month period; deduct only the balance of the 12 months while the client is working.

Example: Client paid $600 in January for an item. Work started in April. Prorate the cost over 12 months. IRWE applies to the balance of the 12 months of employment, or $50 per month for April through December.

2. After work ended: Deduct IRWE from the last month earned income is received.

4. IRWE Categories

DEDUCTIBLE	***NON DEDUCTIBLE***
Attendant Care Services	*Attendant Care Services*
• Performed in work setting or in process of assisting in preparations for work, the trip to/from work and after work (e.g., bathing, dressing, cooking, eating).	• Performed on non-workdays or involving shopping or general homemaking (e.g., cleaning, laundry).
• Services which incidentally benefit the family (e.g., cooking meal for individual also eaten by family).	• Services performed for someone in the family other than the beneficiary (e.g., babysitting).
• Services performed by a family member for a cash fee where the family member suffers an economic loss by reducing or terminating work to perform such services.	• Services performed by a family member for a cash fee where the family member suffers no economic loss.
• Requires verification of duties, of amount of time spent, that they were paid for in cash, and that payment is made on a regular basis.	
Transportation Costs	*Transportation Costs*
• Structural or operational modifications to vehicle, needed to drive to work or be driven to work, even if also used for non-work purposes.	• Cost of a vehicle whether modified or not.
• Driver assistance or taxicabs where such special transportation is not generally required by unimpaired individuals in the community.	• Cost of modification to a vehicle not directly related to the impairment or critical to the operation of the vehicle (e.g., paint or decor preferences).
• Mileage expense limited to travel related to employment.	• Cost of travel related to obtaining medical items or services.

DEDUCTIBLE	NON DEDUCTIBLE
Medical Devices	*Medical Devices*
• Wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment, braces (arm, leg, neck, back).	• Any device not used for a medical purpose.
Work-Related Equipment and Assistants	*Work-Related Equipment and Assistants*
• One-handed typewriters, typing aids (e.g., page-turning devices), electronic visual aids, telecommunications devices for people with hearing impairments and special work tools.	• Any work-related device not paid for by the person with a disability or, in the case of a self-employed individual, equipment previously deducted as a business expense.
• Expenses for a person who serves as a reader for a visually impaired person, expenses for an interpreter for a deaf person, and expenses for a job coach.	
Prosthesis	*Prosthesis*
• Artificial hip and artificial replacement of an arm, leg or other part of the body.	• Any prosthetic device that is primarily for cosmetic purposes.
Residential Modifications	*Residential Modifications*
• Individual Employed Outside Home: Modifications to exterior of house to allow access to street or transportation (e.g., exterior ramps, exterior railings, pathways, etc.).	• Individual Employed Outside Home: Modifications to the house primarily intended to facilitate functioning in the home environment (e.g., enlargement of interior door frames, lowering of kitchen appliances and bathroom facilities, interior railings, stairway chairlift, etc.).
• Individual Self-Employed at Home: Modifications made inside home to accommodate impairment (e.g., enlargement of a doorway leading into an office, etc.).	

- Individual Self-Employed at Home: Any modification expenses previously deducted as a business expense in determining SGA.

DEDUCTIBLE	***NON DEDUCTIBLE***
Routine Drugs/Medical Services	*Routine Drugs/Medical Services*
• Regularly prescribed medical treatment or therapy that is necessary to control a disabling condition (even if unsuccessful), such as anti-convulsion drugs or blood level monitoring, radiation treatment or chemotherapy, corrective surgery for spinal disorders, anti-depressant medication, etc. The physician's fee relating to these services is deductible.	• Drugs and/or medical services used for only minor physical or mental problems (e.g., routine physical exams, allergy treatment, dental exams, optician services, etc.).
Diagnostic Procedures	*Diagnostic Procedures*
• Objective of procedure must be related to the control, treatment or evaluation of a disabling condition (e.g., electroencephalograms. brain scans, etc.).	• Procedures paid for by other sources (e.g., VR, Medicare) or not related to a disabling condition (e.g., allergy testing).
Non-Medical Appliances/Devices	*Non-Medical Appliances/Devices*
• In unusual circumstances, when devices or appliances are essential for the control of disabling condition either at home or in the work setting (e.g., an electric air cleaner for a client with severe respiratory disease); the need is verified by a physician.	• Devices used at home or at the office which are not ordinarily for medical purposes (e.g., portable room heaters, air conditioners, humidifiers, dehumidifiers, etc.) and the client has no verified medical work-related need.
Other Items/Services	*Other Items/Services*
• Medical supplies of an expendable nature (e.g., incontinence pads, elastic stockings, catheters).	• An exercise bicycle or other device used for physical fitness unless verified as necessary by a physician.

- The cost of a guide dog, including food, licenses, and veterinary services.

C. SUBSIDIES

An employer may because of a benevolent attitude toward a handicapped individual subsidize the employee's earnings by paying more in wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy rather than earnings and should be deducted from the gross earnings. Subsidies:

1. *May involve*: giving the impaired worker the same pay but more supervision or fewer/simpler tasks than other non-impaired workers.

2. *May result in*: more pay than the actual work is worth. Workers in sheltered workshops or settings are generally subsidized.

3. *Are deducted*: from gross earnings to arrive at "net countable earnings" for SGA eligibility determinations but are not considered an earned income exemption for budget determinations, once a medical decision is made. They are considered unearned income.

4. *Should be verified*: by an employer contact to confirm a subsidy exists and determine the value of the subsidy.

*Example: Employer states that the value of client's work is half the actual earnings. Client earns $800 per month. As half the work is subsidized, $400 is considered the real value of work and client is not engaging in SGA. **NOTE**: $800 is the non-exempt income for CWD use in computing client's budget.*

D. SPECIAL WORK CONSIDERATIONS

If client is forced to stop working after a short time due to an impairment, the work is generally considered an unsuccessful work attempt (UWA) and earnings from that work will not show ability to do SGA.

1. UNSUCCESSFUL WORK ATTEMPT (UWA) REQUIREMENTS

All of the following must be present for work to be considered an UWA:

- there is a break in client's employment of 30 days or more, and
- work lasted less than six months, and
- work stopped due to client's impairments.

2. EVALUATING UNSUCCESSFUL WORK ATTEMPTS

The following are examples of possible situations which might be encountered when evaluating work activity. How the EW analyzes the situation and what action the EW takes are also provided below.

***EXAMPLE A**: Client worked from 12/1/92 to 6/30/94. Work stopped due to his impairment. He returned to work on 8/5/94 and stopped again on 9/1/94 due to his impairment. He applied on 9/2/94 with a request for retro back to 7/94.*

EW's Analysis

- There is a break in employment of over 30 days between 6/30 and 8/5.
- Work lasted less than six months from 8/5 to 9/1.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate"work after 6/94 is an UWA".
- In Item 6 of MC 221, list retro months of 7/94 and 8/94.

***EXAMPLE B**: Client worked sporadically from 10/93 to 12/93, 3/94 to 4/94 and 6/94 to 7/94 because of his mental illness. He applies on 7/10/94, asking for retro back to 4/94.*

EW's Analysis

- There is a break in employment of over 30 days between each work period.
- Work lasted less than six months for each employment period.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate "work prior to application is an UWA".
- In Item 6 of MC 221, list retro months 4/94, 5/94 and 6/94.

***EXAMPLE C**: Client worked until 5/30/94 and applied on 7/7/94, requesting retro onset to 4/94. CWD determined that client was engaging in SGA in 4/94 and 5/94. In Item 6 of MC 221 that was sent to SP-DAPD, EW Indicated "6/94", and indicated in Item 10 "client engaged in SGA in 4/94 and 5/94". On 8/31/94, client reports a return to work for 8/94 only, but stopped because of her impairment.*

EW's Analysis

- There is a break in employment over 30 days from 5/30 and 8/1.
- Work in 8/94 lasted less than six months.
- Work stopped due to client's impairment.

EW's Actions

- Complete and send MC 222, DAPD Pending Information Update form to SP-DAPD.
- Indicate in Item 9 that client's return to work in 8/94 was an UWA, and that client is no longer working.

E. **In-Kind Income as Earned Income "For SGA Determinations"**

Earned income may be in cash or in kind. In kind income may include value of food, clothing, or shelter, or other items provided instead of cash. If food and/or shelter are not a condition of employment, the current market value of the food, clothing, and/shelter counts as wages (earned income) and would be considered in an SGA determination.

EXAMPLE: Mrs. B. manages an apartment complex. In addition to her salary of $500 per month, she receives free use of an apartment where she lives. It is verified by the owner of the complex that he furnishes the apartment to Mrs. B. so that she will be available for emergencies. The owner would also expect Mrs. B. to respond to emergencies during her off-duty hours. The owner states that Mrs. B. is not required to live in the apartment provided, but would not have hired someone who lived more than two to three miles away.

Since the shelter is not a condition of employment, the current market value of the shelter is considered as earned income. In this example, the MC 272 (SGA Worksheet) would need to be completed with $500 used as payment in kind under number one. Therefore, $500 would be inserted as a monthly earning plus another $500 as payment in kind. If the total of these two incomes, less any IRWEs, is more than the current SGA amount, the individual is considered to be engaging in SGA.

F. **NOTIFICATION**

1. Notifying SP-DAPD

If the CWD performs an SGA evaluation and determines that the individual is not performing SGA, the CWD must annotate in Item 10 (County Worker Comment) of the MC 221 that there is "no SGA issue." The CWD must include a copy of the SGA Worksheet (MC 272) in the disability packet.

If CWD has already sent the disability packet to SP-DAPD, and an SGA issue has been clarified, SP-DAPD should be informed on the evaluation of client's work activity via an MC 222, DAPD Pending Information Update form along with a copy of the MC 272.

If SP-DAPD returns a disability packet to the county as a Z56 for an SGA determination, the CWD must complete an SGA determination. Should the CWD determine that the client is not performing SGA, a **new** MC 221 MUST be completed and resubmitted with a copy of the MC 272.

2. Notifying Client

If client's application is denied due to performance of SGA, client should be sent a Notice of Action (NOA) informing him/her of the reason for the denial. The NOA may contain the following sample statement:

"The reason why you are not entitled to Medi-Cal based on disability is because your earnings of $-------are over the current SGA monthly amount. This means that your net countable earnings are over the current SGA monthly amount of -------- which is the earnings limit if you are working and applying for Medi-Cal as a disabled person"
NOTE: The Title 22 reference section is: **50224**

G. FORMS

1. SGA Worksheet, Form MC 272 (Exhibit 1):

   May be used to compute client's earnings and IRWE/Subsidy deductions.

   a. **Net earnings of current SGA amount or less**: process application in the usual manner.

   b. **Net earnings more than the current SGA amount per month**: deny claim, as client is engaging in SGA.

2. Work Activity Report, Form 273 (Exhibit 2):

   Should be used to determine what client's earnings are and whether the client's gross earnings can be reduced by the amount of any applicable IRWE or subsidy.

3. DAPD Pending Information Update, Form MC 222:

   Must be sent if a disability packet is pending at SP-DAPD, and client is subsequently found to be engaging in SGA. The MC 272 must also be included.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Human Services Agency | Department of Health Services

Name of disabled person	Social security number

SGA WORK SHEET
(Used when gross earned* income is over the current SGA amount.)

1. Earned Income
   - a. Gross average monthly earnings $_____
   - b. Payment in kind (e.g., room and board) which is *not* a condition of employment (use current market value) _____
   - c. Other _____
   - d. **TOTAL GROSS EARNINGS** (add a, b, and c) $ _____
2. Impairment-Related Work Expenses (IRWEs) (see MEPM, Article 22, 22C-2)
   - a. Attendant care services $_____
   - b. Transportation costs _____
   - c. Medical devices _____
   - d. Work-related equipment _____
   - e. Prosthesis _____
   - f. Residential modifications _____
   - g. Routine drugs and routine medical services _____
   - h. Diagnostic procedures _____
   - i. Nonmedical applications and devices _____
   - j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   - k. Other items and services _____
3. **TOTAL IRWEs:** Add (total of 2a through 2k) $ _____
4. **TOTAL SUBSIDY** (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) (from MC 273, number 7) $ _____
5. **NET COUNTABLE EARNINGS** (subtract 3 and 4 from 1d) $ _____
   - Are current countable earnings greater than $ _____? ☐ Yes ☐ No
     (Insert current SGA amount)
   - If the answer is No, send a disability referral to SP-DAPD. In Item 10 of the MC 221, Disability Determination and Transmittal, write in "No SGA issue." Attach copy of MC 272 to the MC 221.
   - If the answer is Yes, the client is engaging in SGA. Deny the disability claim. (Evaluate client for the Working Disabled Program.)

*NOTE: Income information obtained from completed MC 273 (Work Activity Report).

Eligibility Worker signature	Worker number	Date completed

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Human Services Agency | Department of Health Services

WORK ACTIVITY REPORT

This report is for:	
Month	Year

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $_____ *(current SGA amount)* per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: To:	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From: To:	

1. **Gross Earning**—What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2. **Other Payments**—Specify other payments you receive, such as tips, free meals, room, or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **Job Requirements**—Are your job duties listed below different from those of other workers with the same job title?

	Yes	No
a. Shorter hours	☐	☐
b. Different pay scale	☐	☐
c. Less or easier duties	☐	☐
d. Extra help given	☐	☐
e. Lower production	☐	☐
f. Lower quality	☐	☐
g. Other differences (e.g., frequent absences)	☐	☐

5. **Explanation of Job Requirements**—Describe all "yes" answers in item 4 on page 1.

MC 273 (8/01)

6. **Special Work Expenses**—Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

   Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition; diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   _____

   _____

7. **Subsidies**—Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ☐ Yes ☐ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $_____

   b. Explanation of subsidy: _____

   _____

   _____

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   _____

   _____

   _____

   _____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative	Date	Area code and telephone number
		( )

Mailing address (number, street, apartment number, P.O. box number, or Rural Route)

City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $_____
   Does the client have any of the following deductions?
   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No If yes, enter amount: $_____
   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $_____
2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

_____

_____

_____

Eligibility Worker signature	Worker number	Date completed

State of California—Health and Human Services Agency

Department of Health Services

REPORTE SOBRE LA ACTIVIDAD DE TRABAJO

This report is for:	
Month	Year

Es posible que a usted se le considere estar incapacitado(a) para fines de Medi-Cal, si usted n puede realizar ninguna clase de trabajo para el que esté capacitado(a), y solamente si usted no puede trabajar durante por lo menos un año o si su condición resultaría en muerte.

Si sus ingresos brutos son más de $_____ *(actual cantidad de SGA)* al mes, es posible que a usted no se le considere incapacitado(a). es posible que los gastos de trabajo y las consideraciones especiales de trabajo relacionadas con su incapacidad se deduzcan al determinar si sus ingresos cumplen con el límite de ingresos. Por esta razón, se necesita información sobre su actividad de trabajo.

La información que usted proporcione sobre su actividad de trabajo se utilizará al tomar una decisión sobre su caso. Es posible que se establezca contacto con su empleador, para verificar la información que usted proporcione.

Nombre de la persona incapacitada			Número de seguro social	
Nombre del empleador			Número de teléfono del empleador ( )	
Dirección del empleador (número, calle)	Ciudad		Estado	Código postal
Puesto o nombre de su trabajo	Tasa de pago	Horas trabajadas a la semana	Fechas trabajadas (mes/año) Del: _____ Al: _____	
Nombre del empleador			Número de teléfono del empleador ( )	
Dirección del empleador (número, calle)	Ciudad		Estado	Código postal
Puesto o nombre de su trabajo	Tasa de pago	Horas trabajadas a la semana	Fechas trabajadas (mes/año) Del: _____ Al: _____	

1. **Ingresos Brutos**—¿Cuál es su pago mensual bruto? (Si el pago es irregular, usted no necesita anotar la cantidad.) Adjunte sus talones de pago.

2. **Otros pagos**—Especifique otros pagos que usted reciba, como propinas, alimentos, hospedaje o servicios públicos gratuitos. Indique lo que se le dio, y calcule el valor en dólares, así como la frecuencia con que los recibe.

3. **Situaciones Especiales de Empleo**

	Sí	No
Después de que se enfermó, ¿disminuyeron sus obligaciones de trabajo?	☐	☐
Si así fue, ¿pudo mantener el mismo pago?	☐	☐
¿Está usted empleado(a) por un(a) amigo(a) o pariente?	☐	☐
¿Está usted en un programa especial de capacitación o rehabilitación?	☐	☐

4. **Requisitos de Empleo**—¿Son sus tareas de empleo enumeradas enseguida diferentes de aquéllas de otros trabajadores con el mismo puesto?

	Sí	No
a. Horario más corto	☐	☐
b. Diferene escala de pago	☐	☐
c. Menos tareas o tareas más fáciles	☐	☐
d. Se proporciona ayuda adicional	☐	☐
e. Producción más baja	☐	☐
f. Calidad más baja	☐	☐
g. Otras diferencias (por ejemplo, faltas frecuentes)	☐	☐

5. **Explicación de los Requisitos del Empleo**—Describa todas las respuestas a las que respondió "sí" en el inciso 4 en la página 1.

6. **Gastos Especiales de Trabajo**—Especifique a continuación cualesquier gastos especiales relacionados con su condición, que son necesarios para que usted trabaje. Éstas son cosas que usted paga, no cosas que alguien más paga.
   Especifique la cantidad de los gastos. Adjunte comprobante de quién recetó el artículo o servicio necesario, y el costo pagado. (Se nos exige comprobar la necesidad del artículo o servicio con la persona que lo recetó.)
   Ejemplo: Servicios de cuidado de un(a) asistente, costos de transporte, aparatos médicos, equipo relacionado con el trabajo, prótesis, modificaciones a su casa, medicamentos de rutina y servicios médicos necesarios para controlar una condición incapacitante, procedimientos diagnósticos, asistentes (por ejemplo, si se tienen impedimentos de la vista, el costo para contratar a un(a) lector(a); si se tienen impedimentos del oído, el costo para contratar a un intérprete de lenguaje por señas), o artículos o servicios semejantes.

   _____

   _____

7. **Subsidios**—Algunos empleadores apoyan a las personas incapacitadas con subsidios. Por ejemplo, es posible que el empleador subsidie los ingresos de un(a) empleado(a) incapacitado(a) pagando más sueldo que el valor razonable del trabajo real realizado. (Por ejemplo, muchos centros de trabajo protegido subsidian los ingresos de un individuo.)
   ¿Le proporciona su empleador subsidios? ☐ Sí ☐ No
   Si así es, por favor (a) díganos de cuánto es el subsidio y (b) explíquenos la clase de subsidio que se le dio.
   a. $_____
   b. Explicación del subsidio: _____

   _____

   _____

8. Utilice este espacio adicional para contestar cualesquier preguntas anteriores o para dar información adicional que usted cree que será útil.

   _____

   _____

   _____

9. Por favor, lea la siguiente declaración. Firme y feche el formulario. Proporcione la dirección y el número de teléfono.
   Si se tuviera que establecer contacto con mi empleador, esto también autoriza a mi empleador a revelar cualquier información necesaria para que el condado evalúe mi actividad de trabajo para mi solicitud de Medi-Cal basada en incapacidad.
   He completado este formulario correcta y verazmente conforme a mi leal saber y habilidades.

Firma del/de la solicitante o representante	Fecha	Código de área y número de teléfono
		( )

Dirección postal (número, calle, número de departamento, número de apartado postal o ruta rural)

Ciudad	Condado	Estado	Código postal

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $_____
   Does the client have any of the following deductions?
   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No If yes, enter amount: $_____
   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $_____
2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

   _____

   _____

Eligibility Worker signature	Worker number	Date completed

22C-3—DETERMINING PRESUMPTIVE DISABILITY

I. BACKGROUND

Presumptive Disability (PD) decisions temporarily grant Medi-Cal eligibility pending a formal determination by State Programs-Disability Evaluation Division (SP-DAPD). PD categories and documentation requirements are established according to federal regulations.

PD Requirement—County Welfare Departments (CWDs) May Grant PD When:

- The client has a condition that is listed in the "PD Categories" in Section 22c-3-6;
- The condition is verified by a doctor/medical source;
- There was no Title II or Supplemental Security Income (SSI) disability denial in the past 12 months (unless PD is based on a new medical condition not previously considered by Social Security Administration (SSA);
- The client is otherwise eligible; and
- PD is granted effective the month in which the determination is made that the disabling condition meets PD requirements. **Under no circumstance is the county to grant PD for any past months, i.e., retroactively**.

IMPORTANT: If the individual had a federal (i.e., Title II or SSI) denial within the past 12 months, the federal denial is binding on Medi-Cal until the determination is changed by SSA (i.e., through an initial application, reconsideration, hearing, or appeals council review). In such cases, the CWD cannot grant PD unless the individual alleges a new medical condition that was not previously considered by SSA and all of the PD requirements specified above are met.

REMINDER: Only SP-DAPD can grant PD for medical conditions that are not listed on the PD categories chart.

II. RESPONSIBILITIES OF THE CWD AND SP-DAPD

A. CWD

1.	Impairment	Check the PD "categories chart" on page 22C-3.6 to ensure the client's medical condition is listed. **It must match the disability exactly.**
2.	SSA denial	Check for a prior SSA disability denial within the past 12 months. The CWD will need to contact SSA to determine if a prior SSA denial exists. If there is a prior SSA denial, the CWD cannot grant PD **unless** the client alleges a new medical condition that exactly matches a PD category **and** the new impairment was not previously considered by SSA.

If the client alleges a favorable SSA decision within the past 12 months, but a final SSA decision has not yet been made, the SSA decision was most likely an SSI PD. The CWD cannot use the SSI PD as a basis for a Medically Needy Only (MNO) PD.

The CWDs should only grant MNO eligibility based upon PD **IF** the applicant's condition fits a PD category and **IF** the applicant has medical documentation to verify this.

3. Medical Statement Provided

The client's doctor/medical source must verify the impairment on a signed and dated document.

If there is a delay in obtaining verification from the applicant or medical source, **DO NOT** hold the DAPD packet. The county must forward the packet to SP-DAPD as SP-DAPD can also grant PD.

4. MC 221

In item 10 of the MC 221:

- Check the "PD approved" box and
- Document the basis for the PD determination (i.e., impairment/medical condition) using only the impairments listed on the "PD Categories" chart.

5. Effective date

PD determinations shall be granted beginning in the month that the MC 221 is completed and medical verification is obtained.

Do not grant PD from the month of application, unless the required medical verification and the MC 221 are completed in the month of application.

Under no circumstance is the county to grant PD for any past months, i.e. retroactively.

6. Notice to client

Notify the client via a Notice of Action (NOA). Explain to the client that a determination of PD permits temporary Medi-Cal eligibility pending a formal decision by SP-DAPD.

7. Reference

Before sending the disability packet, review the "Presumptive Disability Checklist" on page 22C-3.7A to ensure accurate PD determinations.

B. **SP-DAPD**

1. CWD Notification

If CWD did not grant PD and SP-DAPD finds at any point in case development that a client meets PD criteria as shown in the PD chart, **OR** that available evidence indicates a strong likelihood that disability will be established on formal determination, the appropriate CWD liaison will be contacted by phone/fax.

2. MC 221

When SP-DAPD requests that CWD make a finding of PD, it will indicate in Item 13 of MC 221: "PD granted/denial; phone/faxed to CWD liaison; received by (name of contact) on (date)." This remark will be initialed and dated.

If a PD decision is phoned to CWD, a photocopy of the MC 221 will be mailed to CWD liaison as verification that PD was granted/denied.

3. Formal Decision Made

SP-DAPD will process cases as quickly as possible to make a formal determination.

If disability is not established when a formal decision is made, SP-DAPD will indicate in Item 16 of MC 221: "Previous PD decision not supported by additional evidence."

C. PD IN URGENT CASE SITUATIONS

On occasion, CWDs or SP-DAPD may learn about a client who: 1) is in dire need of an immediate disability decision because of a **disabling** condition which will prevent work activity for 12 months or longer, **and** 2) cannot wait for a formal decision because the delay will pose significant problems to his/her functioning and well-being.

1. SP-DAPD Criteria to Grant PD for Urgent Case Requests

Prior to granting PD, DAPD must evaluate specific criteria to ensure that the client will meet disability requirements when a formal decision is made. SP-DAPD must determine whether the available evidence, short of that needed for a formal decision, shows a strong likelihood that:

- Disability will be established when complete evidence is obtained,
- The evidence establishes a reasonable basis for presuming the individual is currently disabled, and
- The disabling condition has lasted or is likely to last at least 12 months.

2. CWD Urgent Case Requests to SP-DAPD

CWDs may make an urgent case request to SP-DAPD after screening the case for the SP-DAPD PD criteria and ensuring that the client is otherwise eligible. CWDs are urged to make the urgent case request via **fax** rather than mail to expedite SP-DAPD's consideration of a PD decision.

Four **examples** of urgent case requests that may be referred to SP-DAPD are as follows:

a. Client suffered massive head and internal injuries, is comatose, and needs an immediate Medi-Cal decision for transfer to a facility which specializes in head trauma. While client is expected to survive, client is expected to be dependent on a wheelchair for the rest of his life.

b. Client has lung cancer, which has spread to the spine and vital organs. Doctor states client is expected to live six to 12 months longer, even with treatment, and needs aggressive therapy immediately.

c. Client has irreversible kidney failure caused by uncontrolled high blood pressure and is now on renal dialysis. Hospital records and doctors' outpatient notes include lab studies that confirm that kidney function has decreased over the past year and dialysis is required for client to survive. An immediate Medi-Cal decision is necessary to transfer client to an outpatient renal dialysis clinic.

d. Client has severe diabetes. Doctor states a below knee amputation must be performed because of gangrene caused by poor circulation in both legs. Doctor sends reports from earlier hospitalizations, lab studies, progress notes, and a letter specifying the immediate need for a disability decision so that client can be hospitalized for surgery.

3. CWD Actions

a. CWD receives urgent case request from doctor/medical facility; CWD asks for **faxed** medical reports to verify severity of client's condition (e.g., hospital admission and/or discharge summaries, outpatient progress reports, x-ray reports, pathology reports, lab studies and other reports pertinent to the disability).

b. CWD determines that client is **otherwise eligible** and screens request to ensure the SP-DAPD PD criteria will likely be met. CWD liaison **faxes** a full disability packet and medical reports to the following numbers:

Los Angeles Branch: FAX (800) 869-0188
Oakland Branch: FAX (800) 869-0203

Enter comment in Item 10 of MC 221: "Please evaluate for PD" and "Attention: Operations Support Supervisor." CWD fax number should be entered in Item 11 of MC 221.

c. CWD should not delay sending packet prior to receipt of medical reports confirming severity of condition for urgent case request.

d. CWD alerts SP-DAPD via phone/fax about an urgent case request if packet has already been sent. Then the CWD faxes medical reports with an MC 222, "Pending Information Update Form". **Specify in Item 9 of MC 222: "Urgent Case Request-Medical Reports Attached and Packet Sent On (date). "Please evaluate for PD".** Note: CWD must specify when requesting a PD evaluation in order for SP-DAPD to immediately initiate the process.

4. SP-DAPD Actions

a. SP-DAPD immediately reviews request and ensures via systems query, that client has not been previously denied by SSA. If more information is needed to reach a PD decision, the medical source is **phoned** and asked to **fax** additional medical reports.

b. SP-DAPD strives to notify CWD liaison **by phone** OR **by faxing** a copy of the MC 221 within two working days, if possible, about its PD decision. If notification is made by phone, SP-DAPD mails a photocopy of MC 221 to advise CWD liaison whether PD is granted/denied. Item 16 of MC 221 shows: "PD granted/denied; phoned/faxed to CWD liaison; received by (name of contact) on (date)."

c. SP-DAPD continues processing case as quickly as possible to make a formal decision. If PD was granted and disability is not established when a formal decision is made, Item 16 of the MC 221 will show: "Previous PD decision not supported by additional evidence."

D. REMINDERS

1. The PD effective date is the month in which SP-DAPD makes its determination that the client meets PD requirements.

2. PD is granted **prospectively** only (i.e., the month in which the MC 221 is completed and signed medical verification is in file). **PD may be granted in the month of application IF the CWD obtains the required medical documentation and completes the MC 221 in the month of filing. Never grant PD retroactively.**

3. Before granting PD, client must be otherwise eligible.

4. PD cannot be granted if client is performing Substantial Gainful Activity (SGA). SGA is discussed in Article 22 C-2.

5. CWD should not delay sending packet to SP-DAPD pending the receipt of medical reports confirming severity of client's condition for an urgent case request.

6. CWD should ensure that all medical and non-medical documentation that were used to grant PD are included in the disability packet before sending to SP-DAPD. Please refer to the "Presumptive Disability Checklist" on page 22C-3.7A when in doubt.

3. PD CATEGORIES

CWDs may grant PD when client meets any of the following conditions. SP-DAPD granted PDs are not limited to the categories shown below:

NO	IMPAIRMENT CATEGORIES
1	OBSOLETE – Reserved for future use
2	Amputation of a leg at the hip
3	Allegation of total deafness
4	Allegation of total blindness
5	Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition—excluding recent accident and recent surgery
6	Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm
7	Allegation of cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms
8	OBSOLETE – Reserved for future use
9	Allegation of Down Syndrome. **NOTE**: Down Syndrome may be characterized by some indication of mental retardation and by abnormal development of the skull (lateral upward slope of the eyes, small ears, protruded tongue, short nose with a flat ridge, small and frequently abnormally aligned teeth); short arms and legs; and hands and feet that tend to be broad and flat.
10	Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and required care and supervision of routine daily activities. **NOTE**: "Mental deficiency" means mental retardation. This PD category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and doing other routine daily activities (e.g., fastening a seat belt) grossly exceeds age-appropriate dependence as a result of mental retardation.
11	A child has not attained his or her first birthday and the birth certificate or other evidence (e.g., the hospital admission summary) shows a **weight below 1200 grams (2 pounds, 10 ounces) at birth.**
12	Human Immunodeficiency Virus (HIV) infection. (See 22C-3.7 for details on PD.) Completed forms DHS 7035A or DHS 7035c are needed.

13	A child has not attained his or her first birthday and available evidence (e.g., in the hospital admission summary) shows a **gestational age** at birth with the corresponding birth-weight as indicated below: Gestational Age — Weight at Birth 37–40 weeks — Less than 2000 grams (4 pounds, 6 ounces) 36 weeks — 1875 grams or less (4 pounds, 2 ounces) 35 weeks — 1700 grams or less (3 pounds, 12 ounces) 34 weeks — 1500 grams or less (3 pounds, 5 ounces) 33 weeks — At least 1200 grams, but no more than 1325 grams For infants weighting under 1200 grams at birth, see PD category 11. **NOTE**: Gestational age (GA). The age at birth based on the date of conception, may be shown as "GA" as noted in the available evidence, the CWD forwards the case to SP for consideration of a PD finding.
14	A physician or knowledgeable hospice official confirms that an individual is receiving hospice services because of any terminal illness. **NOTE**: Knowledgeable hospice officials include hospice coordinators, staff nurses, social workers, and medical records custodians. The term hospice refers to a program of palliative and supportive care for terminally ill persons. Such services may be provided in the home or in an inpatient facility. Under these guidelines, the hospice benefit is available to individuals who have been certified by a physician to be terminally ill. An individual is considered to be terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less.
15	**Allegations of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held assistive devices for more than two weeks, with confirmation of such status from an appropriate medical professional.**
16	End stage renal disease with ongoing dialysis and the file contains a completed HCFA-2728 or CMS-2728 (End Stage Renal Disease Medical **Evidence** Report-Medicare Entitlement and/or Patient Registration). CWDs should request the HCFA-2728 or CMS-2728 form from the applicant's medical provider. If the provider does not have the form, CWD should acquire the form on line at http://www.ssa.gov/disability/ and send it to the provider. This form is necessary before PD can be granted.
17	Allegation of Amytrophic Lateral Sclerosis (ALS, Lou Gehrigs Disease)

4. INSTRUCTIONS FOR CWD TO GRANT PD FOR HIV INFECTIONS

CWD may grant PD for a client with HIV infection whose medical source confirms, on an HIV form, that client has specific disease manifestations. If client has no medical source, CWD will forward packet to SP-DAPD in the usual manner without preparing an HIV form or granting PD.

If the required HIV criteria are not present, CWD should not grant PD, but should specify "EXPEDITE" in Item 10, "County Worker Comments" section of MC 221.

A. FORMS

Forms used to verify the presence of the HIV and its disease manifestations are:

1. *DHS 7035A* — "Medical Report on **Adult** with Allegation of HIV Infection".

2. *DHS 7035C* — "Medical Report on **Child** with Allegation of HIV Infection". (Client is considered an adult for the purpose of determining PD on the day of his/her 18th birthday.)

Instructional cover sheets attached to the forms contain instructions to the medical source on how to complete them. Copies of forms may be made available to physicians and others, upon request.

B. HANDLING OF FORMS

1. *Appointment Of District Coordinator* — CWDs may wish to appoint a District Coordinator to receive the returned HIV forms to preserve confidentiality of information.

2. *Form Provided To Medical Source For Completion And Return* — CWD generally mails the blank DHS 7035A/ DHS 7035C to the medical source for completion/return to the CWD. It may also be given to client to take to the medical source.

3. *Client Brings Completed Form To CWD* — Client may directly request the medical source to complete the form and may bring it directly to CWD.

4. *Telephone Or Other Direct Contact* — CWD may use telephone or other direct contact to verify presence of the disease manifestations.

   CWD will indicate at signature block "Per telephone conversation of (date) with (medical source)".

PRESUMPTIVE DISABILITY CHECKLIST

The use of this checklist will help to ensure accurate PD determinations made by counties.

A. MC 221 (1/00 revision) See the Medi-Cal Eligibility Procedures Manual Section 22C-3

( )	Does the client's impairment exactly match an impairment on the PD categories chart? CWD should PD **only** if there is a match.
( )	Has there been a prior SSA/SSI denial within the past 12 months? If yes, do not PD unless client alleges a new medical condition that exactly matches the PD categories chart and SSA did not previously consider the new impairment.
( )	Is there a signed and dated verification of the disability/impairment from the applicant's physician or medical source? Is a copy in the DAPD packet?
( )	Is Item 10 on the MC 221 marked "PD approved" and is the basis for PD (i.e., impairments) documented using only the impairments listed on the PD categories chart?
( )	Send the DAPD packet to SP-DAPD immediately if there is any doubt of the impairment or verification is lacking or will be delayed. SP-DAPD can initiate a PD determination if the medical evidence supports it.
( )	Is the effective date of the PD the month in which the MC 221 is completed and PD medical verification is obtained?

C. SIGNATURE ON FORM

1. *Acceptable Signature On Form*

CWD will accept completed forms signed by a medical professional (e.g., physician, nurse, or other member of hospital/clinic staff) who can confirm the diagnosis and severity of the HIV disease manifestations.

2. *Questionable Signature On Form*

If there is a question about the acceptability of the signature, call the medical professional for verification. If the signature cannot be verified, DO NOT GRANT PD. Advise SP-DED of CWD's actions and forward form and packet to SP-DED, if not already sent.

D. CLIENT HAS A MEDICAL SOURCE

CWD will take the following actions:

1. *Authorization For Release Of Medical Information*

a. Complete MC 220 "Authorization for Release of Medical Information", obtain client's signature, and attach the signed MC 220 to the DHS 7035A/DHS 7035C.

b. Check the "Medical Release Information" space of the check-block form "MC 220 attached".

NOTE: While the DHS 7035A/DHS 7035C contains an abbreviated medical release, CWD should use the MC 220. The abbreviated medical release is provided if the form is completed without access to an MC 220.

2. *Completing Section A Of The DHS 7035A/ DHS 7035C*

Enter medical source's name and include client's name, SSN, and date of birth.

3. *Return Envelope*

Prepare a return envelope using the address of the appropriate CWD.

4. *Mailing The Form*

Mail the DHS 7035A/DHS 7035C with attached MC 220 to medical source for completion/return to CWD. Include the specially marked return envelope.

5.	*CWD Actions Pending Return Of The HIV Form*	CWD will not hold disability packet pending receipt of form. Indicate on MC 221 under "County Worker Comments" section that "PD is pending", flag the packet, and forward to SP-DED.
6.	*Form Returned To CWD By Client Or Mail*	a. Review form and verify that it is properly signed (physician, nurse, or other member of hospital/clinic staff). b. Grant PD if the appropriate combination of blocks has been checked or completed (see sections E and F below). c. Contact SP-DED to determine location of original packet and assigned disability evaluation analyst (DEA). d. Attach a cover sheet (MC 222) to form indicating: 1) case name; 2) SSN; 3) date original packet was sent; 4) DEA; and 5) status of pending PD case.
7.	*Information On Client's Condition Received By Telephone Or Other Direct Contact*	a. Complete appropriate blocks on the DHS 7035A/DHS 7035C. b. Indicate at the signature block "Per telephone conversation of (date) with (medical source)". c. Grant PD if applicable. If the packet has already been sent to SP-DED, follow 6c and 6d above.
8.	*Medical Evidence Received By CWD Along With Completed Form*	a. Grant PD, if applicable; forward form and evidence to SP-DED. b. Indicate status of PD decision either on MC 221 or on cover sheet (MC 222). c. If medical evidence is received after form has been received and evaluated, forward it to SP-DED.
9.	*Form Received Via Fax*	a. If quality is poor (e.g., paper darkened by copier), photocopy faxed material (quality of fax deteriorates over time), retain the photocopy, and destroy the original fax.

b. If quality is acceptable, retain original.

10. *Fax Source Is Questionable*

Telephone medical source to verify that the form was faxed by medical source. If unacceptable, do NOT grant PD.

DOCUMENT THE TELEPHONE CONTACT IN THE CASE FILE, advise SP-DED of CWD actions and forward form.

E. EVALUATING THE COMPLETED DHS 7035A (ADULT) FORM

Grant PD if the appropriate blocks have been checked or completed on the DHS 7035A.

1. *At Least One Disease Has Been Checked In Section C*

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

b. Any item has been checked in Section C, *and*

c. Section F has been completed and Section G has been signed.

2. *Repeated Manifestations Of HIV, Section D Has Been Completed*

Criteria in a, b, AND c below must be met:

a. Section B has been checked,

b. Section D (both 1 and 2) has been completed:

- D1 - must indicate the presence of "repeated manifestations of HIV infection".
- D2 - at least one of the criteria shown must be checked, *and*

c. Section F has been completed and Section G has been signed.

"Manifestations of HIV Infection" means conditions that are listed in Section C but do not meet the findings specified there.

"Repeated" means:

- That a condition or combination of conditions occurs an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or
- Does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- Occurs less than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

Exhibits 2 (desk aid for adults with HIV) and 3 (chart with guidelines for evaluating "repeated manifestations") are provided for assistance in granting PD. If CWD has questions as to whether the manifestations are sufficient to grant PD, CWD should send form to SP-DED for the PD.

F. EVALUATING THE COMPLETED DHS 7035C (CHILD) FORM

Grant PD if the appropriate blocks have been checked or completed on the DHS 7035C.

1. *At Least One Disease Has Been Checked In Section C*

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

b. Any item has been checked in Section C (item 6 is used only for a child less than 13 years old), *and*

c. Section F has been completed and Section G has been signed.

2. *Other Manifestations Of HIV, Section D Has Been Completed*

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

b. Section D, item 1 *and* 2 (a, b, or c, depending on child's age) have been completed, *and*

c. Section F has been completed and Section G has been signed.

Exhibit 5 (desk aid for children with HIV) is provided for assistance in granting PD. If CWD

has questions as to whether the manifestations listed are sufficient to grant PD, CWD should send form to SP-DED for the PD.

G. GRANTING PD

1.	*Form Confirms Presence Of HIV, And Required Disease Manifestations*	Grant PD if the medical source confirms that required disease manifestations are present, whether or not the client has Acquired Immunodeficiency Syndrome (AIDS).
2.	*Form Confirms Presence Of HIV, But None Of The Other Conditions Shown On The HIV Form Exist*	DO NOT Grant PD. Process under regular procedures, except that CWD should specify "EXPEDITE" in the "County Worker Comments" section of the MC 221.
3.	*Form Indicates HIV Is Suspected, But Not Confirmed*	DO NOT Grant PD if HIV is NOT confirmed by laboratory tests or clinical findings. Process under regular procedures.
4.	*CWD Grants PD And Packet Has Not Been Sent*	In Item 10, "County Worker Comments" section of MC 221, CWD will check "PD Approved" box and notify client via a NOA that approval is based on PD.
5.	*CWD Grants PD And Packet Has Been Sent*	CWD will confirm location of disability packet and analyst, attach a cover sheet (MC 222) to form including case name, SSN, date original packet sent and status of pending case, and forward form/cover sheet to SP-DED.
6.	*CWD Is Unable To Grant PD*	If CWD is unable to grant PD because form has not been appropriately completed, or for any other reason, forward form and packet, if appropriate, to SP-DED. This allows SP-DED to develop case further.

H. EXHIBITS

1.	*DHS 7035A*	Medical Report on Adult with Allegation of Human Immunodeficiency Virus (HIV) Infection
2.	*Desk Aid*	County Desk Aid for Making a PD Finding in Adult Claims

3.	*Chart*	Evaluating Completion of Section D, Item 1 - "Repeated Manifestations of HIV Infection" of Adult Claim
4.	*DHS 7035C*	Medical Report on Child with Allegation of Human Immunodeficiency Virus (HIV) Infection
5.	*Desk Aid*	County Desk Aid for Making a PD Finding in Child Claims

EXHIBIT 1

State of California—Health and Welfare Agency — Department of Health Services

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 A
(Medical Report on Adult With Allegation of Human Immunodeficiency Virus [HIV] Infection)

Your patient, identified in Section A of the attached form, has filed a claim for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Services medical release (MC 220) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS complete Section B.**
- **Complete Section C, if appropriate.** If you check at least one of the items in Section C, go right to Section E.
- **ONLY complete Section D if you have NOT checked any item in Section C.** See the special information section below which will help you to complete Section D.
- **Complete Section E if you wish to provide comments on your patient's condition(s).**
- **ALWAYS complete Sections F and G. NOTE: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Repeated" Manifestations of HIV Infection *(see Item D.1)*:

"Repeated" means that a condition or combination of conditions:

- Occurs an average of three times a year, or once every four months, each lasting two weeks or more; or
- Does not last for two weeks, but occurs substantially more frequently than three times in a year or once every four months; or
- Occurs less often than an average of three times a year or once every four months but lasts substantially longer than two weeks.

What We Mean By "Manifestations of HIV Infection *(see Item D.1)*:

"Manifestations of HIV infection" may include:

- Any conditions listed in Section C, but without the findings specified there, (e.g., carcinoma of the cervix not meeting the criteria shown in Item 22 of the form, diarrhea not meeting the criteria shown in Item 33 of the form); or any other condition that is not listed in Section C, (e.g., oral hairy leukoplakia, myositis).
- Manifestations of HIV must result in significant, documented symptoms and signs, (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

DHS 7035 A (Cover Sheet) (4/94)

Continued on reverse →

What We Mean By "Marked" Limitation or Restriction in Functioning *(see Item D.2)*:

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

What We Mean By "Activities of Daily Living" *(see Item D.2)*:

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

  Example: An individual with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

What We Mean By "Social Functioning" *(see Item D.2)*:

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.

  Example: An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty in maintaining social functioning.

What We Mean By "Completing Tasks in a Timely Manner" *(see Item D.2)*:

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.

  Example: An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT NOTICE

The Department of Health Services (DHS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHS as follows: (1) to enable a third party or agency to assist DHS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 139a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

DHS 7039 A(Continued) (4/96)

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

Applicant's Signature (Required only if Form MC 220 is NOT attached) ➤	Date

A. IDENTIFYING INFORMATION:

Medical Source's Name	Applicant's Name
Applicant's Social Security Number	Applicant's Date of Birth

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable):

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

7. ☐ **Aspergillosis**
8. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs.
9. ☐ **Coccidioidomycosis,** at a site other than the lungs or lymph nodes.
10. ☐ **Cryptococcosis,** at a site other than the lungs, (e.g., cryptococcal meningitis)
11. ☐ **Histoplasmosis,** at a site other than the lungs or lymph nodes
12. ☐ **Mucormycosis**

PROTOZOAN OR HELMINTHIC INFECTIONS:

13. ☐ **Cryptosporidiosis, Isosporiasis, or Microsporidiosis,** with diarrhea lasting for one month or longer
14. ☐ **Pneumocystis Carinii Pneumonia or Extrapulmonary Pneumocystis Carinii Infection**
15. ☐ **Strongyloidiasis,** extra-intestinal
16. ☐ **Toxoplasmosis,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS:

17. ☐ **Cytomegalovirus Disease,** at a site other than the liver, spleen, or lymph nodes
18. ☐ **Herpes Simplex Virus,** causing mucocutaneous infection, (e.g., oral, genital, perianal) lasting for one month or longer; or infection at a site other than the skin or mucous membranes, (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **Herpes Zoster,** disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **Progressive Multifocal Leukoencephalopathy**
21. ☐ **Hepatitis,** resulting in chronic liver disease manifested by appropriate findings, (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

SECTION C (continued)

MALIGNANT NEOPLASMS:

22. ☐ **Carcinoma of the Cervix, invasive, FIGO stage II and beyond**

23. ☐ **Kaposi's Sarcoma, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive lungating or ulcerating lesions not responding to treatment**

24. ☐ **Lymphoma, of any type, (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)**

25. ☐ **Squamous Cell Carcinoma of the Anus**

SKIN OR MUCOUS MEMBRANES:

26. ☐ **Conditions of the Skin or Mucous Membranes, with extensive lungating or ulcerating lesions not responding to treatment, (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)**

HEMATOLOGIC ABNORMALITIES:

27. ☐ **Anemia (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every two months**

28. ☐ **Granulocytopenia, with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months**

29. ☐ **Thrombocytopenia, with platelet counts repeatedly below 40,000/mm^3 with at least 1 spontaneous hemorrhage, requiring transfusion in the last 5 months; or with intracranial bleeding in the last 12 months.**

NEUROLOGICAL ABNORMALITIES:

30. ☐ **HIV Encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses**

31. ☐ **Other Neurological Manifestations of HIV Infection, (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station**

HIV WASTING SYNDROME:

32. ☐ **HIV Wasting Syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of 1 month or longer**

DIARRHEA:

33. ☐ **Diarrhea, lasting for one month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding**

CARDIOMYOPATHY:

34. ☐ **Cardiomyopathy (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)**

NEPHROPATHY:

35. ☐ **Nephropathy, resulting in chronic renal failure**

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

36. ☐ **Sepsis**

37. ☐ **Meningitis**

38. ☐ **Pneumonia (non-PCP)**

39. ☐ **Septic Arthritis**

40. ☐ **Endocarditis**

41. ☐ **Sinusitis, radiographically documented**

NOTE: If you have checked any of the boxes in Section C, proceed to Section E to add any remarks you wish to make about the patient's condition, then proceed to Sections F and G and sign and date the form.
If you have not checked any of the boxes in Section C, please complete Section D. Proceed to Section E if you have any remarks you want to make about the patients condition. Then proceed to Sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. Repeated Manifestations of HIV Infection, including diseases mentioned in Section C, items 1–41, but without the specified findings described above, or other diseases, resulting in significant, documented symptoms or signs. (e.g., fatigue, fever, malaise, weight loss, pain, night sweats). Please specify:

   a. The manifestations your patient has had;
   b. The number of episodes occurring in the same one-year period; and
   c. The approximate duration of each episode.

   Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same one-year period. (See attached instructions for the definition of "repeated manifestations.")

   If you need more space, please use Section E:

MANIFESTATIONS	NUMBER OF EPISODES IN THE SAME ONE-YEAR PERIOD	DURATION OF EACH EPISODE
EXAMPLE: Diarrhea	3	1 month each

AND

2. Any of the Following:

   ☐ Marked restriction of Activities of Daily Living; or

   ☐ Marked difficulties in maintaining Social Functioning; or

   ☐ Marked difficulties in completing tasks in a timely manner due to deficiencies in Concentration, Persistence, or Pace.

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.):

F. MEDICAL SOURCE INFORMATION (Please Print or Type):

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code) ( )

Date

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in the medical report is true and correct.

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

➤

FOR OFFICIAL USE ONLY

☐ COUNTY OFFICE DISPOSITION: ☐ DISABILITY EVALUATION DIVISION DISPOSITION:

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EXHIBIT 2

COUNTY DESK AID FOR MAKING A PD FINDING IN ADULT CLAIMS

The County Will Make A PD Finding If:	The Following Combination of Blocks Have Been Completed, And The Blocks Have Been Completed as Indicated Below:	
	Section B	Either block has been checked
	Section C	One or more blocks have been checked
	Section F	Medical source's name and address have been completed
	Section G	Signature block has been completed
	OR	
	Section B	Either block has been checked
	Section D	Item 1 - has been completed showing manifestations of HIV infection that are repeated as shown in Exhibit 3
		Item 2 - one or more blocks have been checked
	Section F	Medical source's name and address have been completed
	Section G	Signature block has been completed

EXHIBIT 3

EVALUATING COMPLETION OF SECTION D; ITEM 1 - "REPEATED MANIFESTATIONS OF HIV INFECTION" OF ADULT CLAIM

IF: HIV manifestations listed in Section D include diseases mentioned in Section C; items 1-41 of the DHS 7035A, but without the specified findings discussed there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or any other manifestations of HIV not listed in Section C. (e.g., oral leukoplakia, myositis)*

AND:	AND:	THEN:
Number of Episodes of HIV Manifestations In The Same 1-Year Period is:	Duration of Each Episode is:	
At least 3	At least 2 weeks	Requirement is met
Substantially more than 3	Less than 2 weeks	Requirement is met
Less than 3	Substantially more than 2 weeks	Requirement is met
Unable to determine	Unable to determine	Refer to DED

*REMINDER: If there is any question as to whether the manifestation listed is a manifestation of HIV, refer to DED

ALERT: The same manifestations need not be represented in each episode.

Examples

Manifestation(s)	Episodes	Duration	Requirement Is Met?
Anemia	2	2 months each time	Yes[1]
Diarrhea Bacterial Infection	2 1	3 weeks each time 2 ½ weeks	Yes[2]
Pneumonia	2	1 week each time	No[3] (Refer to DED)

1 The requirement is met based on less than 3 episodes of anemia, each lasting substantially more than 2 weeks.

2 The requirement is met based on a total of 3 episodes of diarrhea and bacterial infection, each lasting at least 2 weeks.

3 The requirement is not met because there are less than 3 episodes of pneumonia and each episode did not last substantially more than 2 weeks.

EXHIBIT 4

State of California—Health and Welfare Agency — Department of Health Services

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 C
(Medical Report on Child With Allegation of Human Immunodeficiency Virus [HIV] Infection)

A claim has been filed for your patient, identified in Section A of the attached form, for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Services medical release (MC 220) signed by your patient's parent or guardian should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient's parent or guardian.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient's parent or guardian and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- ALWAYS complete Section B.
- Complete Section C, if appropriate. If you check at least one of the items in Section C, go right to Section E.
- ONLY complete Section D if you have NOT checked any item in Section C. See the special information section below which will help you to complete Section D.
- Complete Section E if you wish to provide comments on your patient's condition(s).
- ALWAYS complete Sections F and G. NOTE: This form is not complete until it is signed.

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient's parent or guardian for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected. Complete only the areas of functioning applicable to the child's age group.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to the extent described.
- For children age 3 to attainment of age 18, the child must have a "marked" restriction of functioning in two areas to be eligible for these benefits. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Manifestations of HIV Infection" *(see Item D.1)*:

"Manifestations of HIV Infection" may include any conditions listed in Section C, but without the findings specified there, (e.g., oral candidiasis not meeting the criteria shown in Item 27 of the form, diarrhea not meeting the criteria shown in Item 38 of the form); or any other conditions that is not listed in Section C, (e.g., oral hairy leukoplakia, hepatomegaly).

What We Mean By "Marked" *(see Item D.2.c—Applies Only to Children Age 3 to 18)*:

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or placed in a residential treatment facility.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively in an age-appropriate manner.

DHS 7035 C (Continued) (4/94)

Continued on reverse →

PRIVACY ACT NOTICE

The Department of Health Services (DHS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHS as follows: (1) to enable a third party or agency to assist DHS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 1396a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

DHS 7038 C(Corrected) (4/94)

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding the child's treatment for human immunodeficiency virus (HIV) infection.

Applicant's Parent's or Guardian's Signature (Required only if Form MC 220 is NOT attached)	Date
➤	

A. IDENTIFYING INFORMATION:

Medical Source's Name	Applicant's Name
Applicant's Social Security Number	**Applicant's Date of Birth**

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable):

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **In a child less than 13 years of age, Multiple or Recurrent Pyogenic Bacterial Infection(s)** of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring two or more times in two years
7. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

8. ☐ **Aspergillosis**
9. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes, or candidiasis involving the esophagus, trachea, bronchi, or lungs
10. ☐ **Coccidioidomycosis,** at a site other than the lungs or lymph nodes
11. ☐ **Cryptococcosis,** at a site other than the lungs, (e.g., cryptococcal meningitis)
12. ☐ **Histoplasmosis,** at a site other than the lungs or lymph nodes
13. ☐ **Mucormycosis**

PROTOZOAN OR HELMINTHIC INFECTIONS:

14. ☐ **Cryptosporidiosis, Isosporiasis, or Microsporidiosis,** with diarrhea lasting for one month or longer
15. ☐ **Pneumocystis Carinii Pneumonia or Extrapulmonary Pneumocystis Carinii Infection**
16. ☐ **Strongyloidiasis,** extra-intestinal
17. ☐ **Toxoplasmosis,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS:

18. ☐ **Cytomegalovirus Disease,** at a site other than the liver, spleen, or lymph nodes
19. ☐ **Herpes Simplex Virus,** causing mucocutaneous infection, (e.g., oral, genital, perianal) lasting for one month or longer; or infection at a site other than the skin or mucous membranes, (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
20. ☐ **Herpes Zoster,** disseminated or with multidermatomal eruptions that are resistant to treatment
21. ☐ **Progressive Multifocal Leukoencephalopathy**

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SECTION C (continued)

22. ☐ **Hepatitis,** resulting in chronic liver disease manifested by appropriate findings, (e.g., intractable ascites, esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS:

23. ☐ **Carcinoma of the Cervix,** invasive, FIGO stage II and beyond

24. ☐ **Kaposi's Sarcoma,** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

25. ☐ **Lymphoma** of any type, (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)

26. ☐ **Squamous Cell Carcinoma of the Anus**

SKIN OR MUCOUS MEMBRANES:

27. ☐ **Conditions of the Skin or Mucous Membranes,** with extensive fungating or ulcerating lesions not responding to treatment, (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES:

28. ☐ **Anemia** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every two months

29. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

30. ☐ **Thrombocytopenia,** with platelet count of 40,000/mm^3 or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or platelet counts repeatedly below 40,000/mm^3 with at least 1 spontaneous hemorrhage, requiring transfusion, in the last 5 months; or with intracranial bleeding in the last 12 months

NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION (E.G., HIV ENCEPHALOPATHY, PERIPHERAL NEUROPATHY) RESULTING IN:

31. ☐ **Loss of Previously Acquired, or Marked Delay in Achieving, Developmental Milestones or Intellectual Ability** (including the sudden acquisition of a new learning disability)

32. ☐ **Impaired Brain Growth** (acquired microcephaly or brain atrophy)

33. ☐ **Progressive Motor Dysfunction** affecting gait and station or fine and gross motor skills

GROWTH DISTURBANCE WITH:

34. ☐ **Involuntary Weight Loss (or Failure to Gain Weight) at an Appropriate Rate for Age) Resulting in a Fall of 15 Percentiles** from established growth curve (on standard growth charts) that persists for 2 months or longer

35. ☐ **Involuntary Weight Loss (or Failure to Gain Weight) at an Appropriate Rate for Age) Resulting in a Fall to Below Third Percentile** from established growth curve (on standard growth charts) that persists for two months or longer

36. ☐ **Involuntary Weight Loss Greater Than Ten Percent of Baseline** that persists for two months or longer

37. ☐ **Growth Impairment,** with fall of greater than 15 percentiles in height which is sustained; or fall to, or persistence of, height below the third percentile

DIARRHEA:

38. ☐ **Diarrhea,** lasting for one month or longer; resistant to treatment; and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

39. ☐ **Cardiomyopathy** (chronic heart failure; or other severe cardiac abnormality not responsive to treatment)

PULMONARY CONDITIONS:

40. ☐ **Lymphoid Interstitial Pneumonia/Pulmonary Lymphoid Hyperplasia** (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment

NEPHROPATHY:

41. ☐ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

42. ☐ **Sepsis**

43. ☐ **Meningitis**

44. ☐ **Pneumonia** (non-PCP)

45. ☐ **Septic Arthritis**

46. ☐ **Endocarditis**

47. ☐ **Sinusitis,** radiographically documented

NOTE: If you have checked any of the boxes in Section C, proceed to Section E to add any remarks you wish to make about the patient's condition; then proceed to Sections F and G and sign and date the form.

If you have not checked any of the boxes in Section C, please complete Section D. Proceed to Section E if you have any remarks you want to make about the patients condition. Then proceed to Sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. **Any Manifestations of HIV Infection Including Any Diseases Listed in Section C, Items 1–47, but without the specified findings described above, or any other manifestations of HIV infection; please specify type of manifestation(s):**

_____

_____

_____

AND

2. **Any of the Following Functional Limitation(s), Complete Only the Items for the Child's Present Age Group:**

   a. **Birth to Attainment of Age One**—Any of the following:

      (1) ☐ **Cognitive/Communicative Functioning** generally acquired by children no more than one-half the child's chronological age, (e.g., in infants birth to six months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing); or

      (2) ☐ **Motor Development** generally acquired by children no more than one-half the child's chronological age; or

      (3) ☐ **Apathy, Over-Excitability, or Fearfulness**, demonstrated by an absent or grossly excessive response to visual stimulation, auditory stimulation, or tactile stimulation; or

      (4) ☐ **Failure to Sustain Social Interaction** on an ongoing, reciprocal basis as evidenced by inability by six months to participate in vocal, visual, and motoric exchanges (including facial expressions); or failure by age nine months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age; or

      (5) ☐ **Attainment of Development or Function** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social).

   b. **Age One to Attainment of Age Three**—Any of the following:

      (1) ☐ **Gross or Fine Motor Development** at a level generally acquired by children no more than one-half the child's chronological age; or

      (2) ☐ **Cognitive/Communicative Function** at a level generally acquired by children no more than one-half the child's chronological age; or

      (3) ☐ **Social Function** at a level generally acquired by children no more than one-half the child's chronological age; or

      (4) ☐ **Attainment of Development or Function** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by 1, 2, or 3.

   c. **Age 3 to Attainment of Age 18**—Limitation in at least 2 of the following areas:

      (1) ☐ **Marked impairment in age-appropriate Cognitive/Communicative Function** (considering historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

      (2) ☐ **Marked impairment in age-appropriate Social Functioning** (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

      (3) ☐ **Marked Impairment in Personal/Behavioral Function** as evidenced by marked restriction of age-appropriate activities of daily living (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

      (4) ☐ **Deficiencies of Concentration, Persistence, or Pace** resulting in frequent failure to complete tasks in a timely manner.

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.):

F. MEDICAL SOURCE INFORMATION (Please Print or Type):

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code) | Date

( )

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in the medical report is true and correct.

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

➤

FOR OFFICIAL USE ONLY

☐ COUNTY OFFICE DISPOSITION:

☐ DISABILITY EVALUATION DIVISION DISPOSITION:

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EXHIBIT 5

COUNTY DESK AID FOR MAKING A PD FINDING IN CHILD CLAIMS

The County Will Make A PD Finding If:	The Following Combination of Blocks Have Been Completed, AND The Blocks Have Been Completed as Indicated Below:
	Section B — Either block has been checked
	Section C — One or more blocks have been checked
	ALERT: Item 6 applies only to a child less than 13 years of age
	Section F — Medical source's name and address have been completed
	Section G — Signature block has been completed
	OR
	Section B — Either block has been checked
	Section D — Item 1 - has been completed
	AND
	Birth to attainment of age 1 - One or more of the blocks in item 2a has been checked,
	OR
	Age 1 to attainment of age 3 - One or more of the blocks in item 2b has been checked,
	OR

	Age 3 to attainment of age 18 - At least two of the blocks in item 2c have been checked
	ALERT: The appropriate item 2a., b., or c. should be checked based on the child's age
Section F	Medical source's name and address have been completed
Section G	Signature block has been completed

22 C-4 -- COMPLETING DISABILITY EVALUATION FORMS

1. MC 017/MC 017 (SP) -- WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION

This is an optional form which may be given to client who wishes to pursue a Med-Cal application based on disability. This informational form gives client an overview of what can be expected when an application based on disability is filed.

2. MC 179/MC 179 (SP) -- 90 DAY STATUS LETTER

A. BACKGROUND

Section 50177 of Title 22 of the California Code of Regulations requires CWDs to complete the determination of eligibility no later than 90 days from the date the client requests Medi-Cal based on disability or blindness. To ensure timeliness, the Radcliffe and Harris v. Coye, et al (Radcliffe) lawsuit specified that:

- Independent disability determinations be made within the time limit required by law; and
- A status letter be issued to client whose disability determination would not be decided within 90 days.

Form MC 179 was developed for client notification by CWD if a disability packet has not been sent to SP-DED by the 80th day from the date disability or blindness is alleged. It informs client of reason(s) for a delay in the claim processing.

The 80th day is counted from the date specified in Item 5 of the MC 221. For **APPLICANT**, date should be the SAWS 1 date; for **BENEFICIARY**, the date should be the date of the most recent MC 223, Applicant's Supplemental Statement of Facts.

B. COMPLETING THE MC 179

The MC 179 (English and Spanish) was developed for CWD use only. This status letter informs client that there has been a delay in processing the disability-based Medi-Cal claim and the reason(s) why the claim has not been referred to SP-DED. The status letter provides check blocks and blank spaces for completion by CWD.

It informs client that "We are awaiting the following information":

- For you to respond to our request for additional information. (CWDs may use their discretion as to inserting additional information on the blank lines.);
- For you to respond to our request to come into the office;

- For you to contact your eligibility worker RIGHT AWAY because your disability form(s) is not completed correctly; and
- Other. (Specify reason(s) in space provided.)

C. WHEN THE MC 179 IS USED

County MUST issue MC 179 in the following situations:

1. No later than the 80th day from date Medi-Cal based on disability is requested, if disability packet has not been submitted to SP-DED, or
2. At any time prior to the 80th day if CWD knows that the packet will not be sent by the 80th day, or
3. If on the 80th day, CWD has a returned SP-DED referral packet, or
4. If CWD received a letter from SP-DED that the MC 179 was missing when SP-DED received the referral packet on the 86th day or later. Attach copy of MC 179 sent to client to a copy of SP-DED's letter with the comment "see attached" on SP-DED's letter, and send to SP-DED.

D. SEND COPY OF MC 179 TO SP-DED

1. Attach copy of MC 179 to SP-DED disability packet if packet has not been sent by the 80th day, is not expected to be sent by the 80th day, or if on the 80th day or later CWD has a returned disability packet.

   Check box in item 10 of the MC 221 which specifies "(MC 179) 90-Day Status Letter Attached" to inform SP-DED that the letter was sent to client.

2. Attach copy of MC 179 to copy of SP-DED's form letter (OX 9 from Oakland Branch or LAX 9 for LA Branch) which informed CWD that case was received by SP-DED after the 86th day without a copy of the MC 179 included. Enter comment "see attached" on copy of SP-DED's letter.

3. MC 220 -- AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

A. HOW THE MC 220 IS USED

The MC 220 authorizes the release of medical records, including testing and treatment records, for medical conditions including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC) patients.

B. ONE MC 220 PER TREATING SOURCE

An MC 220 signed and dated by client is required for each treating source (one who has treated client for a significant medical problem), testing facility, or agency listed on the MC 223, except for Social Security. Only one treating source may be designated per signed MC 220. Three extra MC 220's containing the client's signature and date should be obtained.

C. HOW TO COMPLETE THE MC 220

1.	*Do*:	Enter client's name, Social Security Number, name of doctor, hospital, or clinic where treatment was received, and hospital or clinic record number.
2.	*Do Not*:	Enter address of treating source or beginning and ending dates of treatment. They will be completed by SP-DED. However, if request is for alcohol or drug abuse information, form should be completely filled out.
3.	*Do*:	Ask the applicant to date the MC 220's. The forms are valid for 90 days from the date entered. Forms dated more than 90 days prior to SP-DED's receipt will be returned to CWD.
4.	*Do Not*	Send the MC 220's to SP-DED if it is noted that the time is getting close to expiring on the 90-day limit, instead request that the client complete more MC 220's with a current date. If SP-DED receives MC 220's that are not dated by the client, the DED packet will be accepted and will not be returned to the CWD.
5.	*Do Not*:	Alter, cross out, white out, or make changes to MC 220, as these are not acceptable to treating source. Any altered MC 220 will be returned by SP-DED.
6.	*Do Not*:	Send MC 220's with photocopied signatures, as they are not acceptable to treating source.
7.	*Do*:	Send three extra MC 220's which contain only client's signature and date. These are used when additional treating sources are identified during case development.

D. SIGNATURE REQUIREMENTS

The MC 220 may be signed by:

- Client;
- Legal representative of a minor or incompetent client;
- Legal or personal representative of a client physically incapable of signing; or
- Personal representative of an incompetent or deceased client.

When requesting the release of medical information pertaining to minor consent services as specified in Article 19B, the minor (who has attained the age of 12) must sign the release.

Special considerations on handling MC 220's are as follows:

1. Client Has A Guardian Or Conservator

   The MC 220 must include signature of guardian or conservator. Enter relationship to client next to signature (e.g., legal guardian).

2. The Client Is Incompetent Or Physically Incapable of Signing

   If client is incompetent or physically incapable of signing, and does not have a guardian or conservator, MC 220 may be signed by the legal or personal representative who is acting on client's behalf. Enter relationship to client next to signature (e.g., spouse, mother, friend). Specify reason why client cannot sign MC 220 below signature line.

3. The Client Can Only Sign With A Mark

   If client can only sign with a mark (e.g., "X") or other unrecognizable symbol (e.g., non-English character), MC 220 must include:

   - Signature or mark of client;
   - Client's name, written next to the "X" or symbol;
   - Signature of witness. NOTE: Witness signatures with an "X" or other unrecognizable symbol are not acceptable; and
   - Relationship of witness to client.

E. WRITTEN AUTHORIZED REPRESENTATIVE (AR) DOCUMENT IN FILE

The client may designate any person to become his/her AR as long as some type of written authorization is provided by the client. The written authorization does not need to be on any specific form or document. A signed AR document grants another person authority to accompany, assist, and represent a client during application for or redetermination of Medi-Cal benefits. But it does not permit the AR to sign MC 220's,

unless the client is incompetent. The eligibility worker (EW) is responsible for ensuring that the written authorization, used to give the AR the power to act on the client's behalf, is signed and dated by both the AR and the client, and to the best of the EW's knowledge, the actions the client wants the AR to perform at the time he or she provides this document. A copy of the AR document must be included in the packet sent to SP-DAPD to allow contact with the AR. If the AR document is received after the packet has been sent to SP-DAPD, the EW shall then send the document via the MC 222 "Disability Evaluation Division Pending Information Update" form. SP-DAPD will not accept an AR document that did not come through the WD.

MC 220's must be signed by client unless client is a minor, has a guardian or conservator, is incompetent or physically incapable of signing the releases.

4. MC 221—DISABILITY DETERMINATION AND TRANSMITTAL

A. USE OF FORM

This is the transmittal and determination document shared between county welfare department and SP-DAPD. It is used only for new applications or resubmitted disability cases to SP-DAPD.

Note: If a case is pending in SP-DAPD, Do Not use the MC 221 to update SP-DAPD regarding any changes or to provide new information. Use MC 222-DAPD Pending Information Update form instead.

The reverse side of this form provides information on how to complete items 5, 6, and 8.

B. HOW TO COMPLETE THE MC 221

Items 1 to 4, and 7:	Provides vital information on the applicant.
Item 2:	If the Social Security number is pending, the word "Pending" should be inserted or an explanation as to why there is no number. If left blank, the packet will be returned to CWD.
Item 5:	The month, day, and year must be provided. For **APPLICANT,** insert the SAWS1 date. For **BENEFICIARY** who alleges blindness or disability, the date must reflect date CWD becomes aware that beneficiary is requesting a reclassification to a disabled category (the date will most likely be date on MC 223). This is the beginning date for the 90–day promptness requirement of Section 50177 of Title 22 of the California Code of Regulations.
Item 6:	List each separate month for which retroactive coverage is requested (not more than three months prior to application date).
Item 8:	Check all applicable boxes.
Item 9:	Check if applicant is currently in a hospital and identify hospital. If checked, include MC 220 for hospitals.
Item 10:	Insert information CWD needs to relay to SP-DAPD. Attach additional sheets or forms, such as the DHS 7045 (Worker Observation form), as needed. If additional sheets or forms are attached, check "See Attached Sheet" box.

NOTE: If MC 179 is attached, check "90 Day Status Letter Attached" box. If Presumption Disability (PD) was granted, check the "PD Approved" box.

Items 11 and 12: CWD worker information and date sent must be clearly identified.

Items 13 to 17: These will be completed by SP-DAPD. These boxes inform CWD if case decision are found in Section 22 C-8—Processing SP-DAPD Decisions.

NOTE: If SP-DAPD forwarded a packet to another Branch to "equalize" its caseload, a box at the bottom of form ("Oakland" or LA") will be checked to specify the Branch to which jurisdiction was transferred. A copy of the MC 221, with one of the boxes checked, will be sent to CWD by the receiving Branch ONLY if a case is "equalized." This alerts CWD that the case is assigned to a Branch other than the one to which a packet was sent.

5. MC 222 LA/MC 222 OAK -- DAPD PENDING INFORMATION UPDATE

A. USE OF FORM

This form is sent to SP-DAPD when CWD becomes aware of new or changed information affecting a pending case. CWDs who send disability packets to Los Angeles SP-DAPD will use MC 222 LA. Other CWDs who send packets to Oakland SP-DAPD will use MC 222 OAK. Use of this form replaces the updating of SP-DAPD via an MC 221, which will be used only for new applications and resubmitted cases.

B. CHANGES TO REPORT TO SP-DAPD

CWDs will report the following changes to SP-DAPD while a disability case is pending in SP-DAPD:

1. Change in client's address;
2. Change in client's name, telephone, or message number;
3. Denial or discontinuance of client on basis of non-medical information (e.g., excess property);
4. Withdrawal of application;
5. Cancellation of Authorization for Release of Information (MC 220) by client;

6. Death of client;
7. Receipt of new medical evidence (attach new medical evidence to MC 222);
8. Availability of interpreter (provide name and phone number);
9. Change in EW; and
10. Any other pertinent information which affects SP-DED's actions on a pending case.

6. MC 223 -- APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL (ENGLISH/SPANISH)

The MC 223 helps SP-DED obtain a clear and accurate picture of client's disabling condition(s). Client should identify **ALL** pertinent medical, vocational, social and/or third party sources who can provide relevant information regarding his/her condition. Addresses and telephone numbers where the sources can be located **MUST** be provided.

A. IMPACT OF SSA'S DECISION

The 1990 revisions to 42 CFR 435.541 clarify the controlling nature of SSA's disability decisions when client has made both an SSA disability application and a Medi-Cal application based on disability. These revisions specify when client must be referred back to SSA or SP-DED.

It is extremely important that client inform CWD if there was an SSA disability decision in the past, or if there is a current SSA disability claim or appeal pending.

B. QUESTIONS WHICH PERTAIN TO AN SSA DECISION

Questions 5 through 5D help CWD decide whether to deny an application for Medi-Cal based on disability and refer client to SSA, or whether to refer client to SP-DED for an independent disability decision.

C. HOW TO COMPLETE THE MC 223

EWs should assist client in completing form thoroughly, as incomplete forms may result in case delays. Any discrepancy, especially in personal information, should be resolved before sending case to SP-DED.

Parts I and II below, Personal and Medical Information, should be completed by client as much as possible. Any corrections should be initialed. CWD staff should write any information which may be helpful for case processing in margin designated as "County Use Only".

PART 1 - PERSONAL INFORMATION

Item 1a Provide full name.

Item 1b Include Social Security Number. If none exists, indicate "Pending" on "N/A" (applies to all cases). DO NOT leave blank.

Item 1c Specify month, day AND year of birth.

Item 1d Provide all known alias(es).

Item 1e Specify if male or female.

Item 1f-g Provide height in feet and inches, and weight in pounds.

Item 2a-b Provide residence address. Specify mailing address if different.

Item 3 Provide area code and phone number. Indicate if there is no phone or if there is a message number. Specify best time to call.

Item 4a-b Indicate if English is spoken; if not, specify language spoken. If interpreter is available, indicate name, phone number and best time to call.

PART II - MEDICAL INFORMATION

Item 5 Indicate if client applied for Social Security or Supplemental Security Income (SSI) disability benefits within the past two years.

NOTE: CWD will review client's responses to Items 5-5d.

- If "no", submit disability packet to SP-DED.
- If "yes", consider the following questions on client's SSA disability claim:
  - did SSA approve claim?
  - did SSA deny claim or is status unknown or pending?
  - was decision made within or more than 12 months of the Medi-Cal application?
  - was SSA's denial appealed?
  - has client's condition worsened or have new medical problems developed?
- If "yes", refer to the following chart which specifies whether case should be referred to SSA or SP-DED. If client is referred to SSA, CWD will deny the disability application and issue denial NOA, MC 239 SD (3/92), and Important Information Regarding Your Appeal Rights - Social Security Information, MC Information Notice 13 (3/92).

Item 19E through 19G - Indicate highest grade completed or year GED test was passed. If client is unable to read or write despite stated educational level, enter "functional illiterate" next to grade level. If client attended special education classes, enter "special education" next to grade level.

Item 20 - Indicate employment within the last 15 years. If work was performed during the past 15 years, complete Part 2 of form.

PART 2 - VOCATIONAL INFORMATION

Items 1 and 2 - Enter client's name and Social Security Number.

Items 6a and 6b - Enter job title and dates worked. Provide job description, as job performed may differ from what is described in the Dictionary of Occupational Titles (DOT) which lists jobs performed in the national economy. If no description is provided by client, SP-DED will use DOT's job description.

If more than two jobs were performed in the last 15 years, give client extra copies of "Part 2 - Vocational Information" to complete.

Highlights Of What To Include In Job Description:

- Types of tools, machines or equipment used;
- Whether writing or supervisory duties were involved;
- Frequency and weight of lifting involved;
- Hours spent sitting, standing and walking;
- Other exertional requirements, such as climbing or bending; and
- Description of alterations made to job functions to accommodate impairments, such as special equipment or changes in duties

7. MC 272 – SGA WORKSHEET

This worksheet is used when applicant has gross earned income of over $500.

Section I Add gross average earnings. Include in-kind payments received, such as room and board, and any other income, such as tips.

Section II Compute allowable Impairment-Related Work Expenses (IRWE is explained in detail in Article 22 C-1 – Determining SGA) and deduct from gross earnings.

Section III If applicant's work is subsidized (as specified in Article 22 C-1), indicate what subsidy is worth.

Section IV "Net countable earnings", after deductions, should be $500 or less in order for case to be referred to SP-DED. If above $500, client is performing SGA and ineligible for Disabled-MN.

8. MC 273 -- WORK ACTIVITY REPORT (ENGLISH/SPANISH)

Form is provided to applicant to inform him/her about the $500 SGA limit. It gives applicant the opportunity to provide information leading to IRWE or subsidy deductions.

Items 1 to 8	Applicant completes these items.
Item 9	EW indicates if (a) subsidy or (b) IRWE is applied to gross earned income and if applicant is found to be engaging in (c) SGA.
	EW indicates in "Explanation" section how a decision of SGA or non-SGA was determined.

9. MC 4033 -- UPDATE TO DISABILITY LIAISON LISTS

CWD completes MC 4033 to notify the state of any updates needed for designated liaisons and mailing lists for either:

- MEDI-CAL LIAISON(S) FOR DISABILITY ISSUES, or
- MEDI-CAL LIAISON(S) FOR QUARTERLY STATUS LISTINGS FOR PENDING AND CLOSED DISABILITY CASES.

Check appropriate listing being changed. Specify items being updated. Complete a separate form for each representative and corresponding information being updated. Print or type the information. Send form to DHS-MEB.

10. DHS 7035A / DHS 7035C -- MEDICAL REPORT ON ADULT/CHILD WITH ALLEGATION OF HIV

DHS 7035A is used for an adult, and DHS 7035C for a child, who alleges HIV, AIDS or ARC. These are completed by a medical source when client alleges having Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC). Upon receipt of form, CWD processes case under Presumptive Disability (PD) criteria.

Article 22 C-2 -- Determining Presumptive Disability discusses in detail how this form is used and evaluated.

PART III - SOCIAL AND EDUCATIONAL INFORMATION

Item 14 Indicate what daily activities are participated in and how they are affected by the medical condition(s). This is helpful to SP-DED, especially in mental or emotional disorders.

Item 15a-c Indicate highest grade or if GED completed, when it was completed, or if special education classes were involved.

CWD must not guess at the client's educational background or the level of education completed. Incorrect response(s) could result in an erroneous disability denial or approval. The client should be contacted if information on education is incomplete or omitted. If the client states that he/she does not know what level of education was completed or information is not available, CWD should note this in the right margin (e.g., *"Client states level of education unknown/not available"*). DO NOT leave this section blank.

NOTE: If the CWD observes that the client is illiterate or any inconsistency is noticed, it should be noted in the right margin or in Item 10, County Worker Comment(s), of the MC 221. CWD could note, for example, client is illiterate or client indicates an eighth grade education but has significant difficulties in reading, writing or understanding. If there are additional observations that the CWD feels may be of benefit to SP-DED, the CWD may include them on the form, DHS 7045 (Worker Observations - Disability).

Item 16 Specify if there was work activity which was performed for more than 30 days during the last 15 years. This includes any relevant work which was performed outside of the United States.

If "yes", complete Part IV.

PART IV - WORK HISTORY

Item 17 Enter job title, dates worked and job description. Be sure to also include any relevant job(s) which was performed outside of the United States. If no description is provided, SP-DED will use the job description in the Dictionary of Occupational Titles.

Highlights Of What To Include In Job Description:

- Types of tools, machines or equipment used;
- Whether writing or supervisory duties were involved;
- Frequency and weight of lifting involved;
- Hours spent sitting, standing and walking;
- Other exertional requirements, such as climbing or bending; and
- Description of alterations made to job functions to accommodate impairments, such as special equipment or changes in duties

PART V - SIGNATURE AND CERTIFICATION

- Enter proper signature(s) and current date.

  NOTE: CWD will provide client three extra MC 220's (7/93) for client's signature only.

7. MC 239 SD -- MEDI-CAL NOTICE OF ACTION - DENIAL OF BENEFITS DUE TO A FEDERAL SOCIAL SECURITY DISABILITY DETERMINATION (ENGLISH/SPANISH)

If the following exist, SP-DED is not allowed to make an independent decision and CWD must complete MC 239 SD to notify client that case is denied.

- SSA has denied a disability claim on the same condition(s) which is (are) alleged on the Medi-Cal application based on disability AND the application is within 12 months of the SSA denial AND client has a worsening of his/her condition.

OR

- The Medi-Cal application based on disability is within 12, or more than 12 months of the SSA denial AND client has no changes or new condition(s).

8. MC INFORMATION NOTICE 13 -- IMPORTANT INFORMATION REGARDING YOUR APPEAL RIGHTS/SOCIAL SECURITY INFORMATION (ENGLISH/SPANISH)

This notice is used in conjunction with Medi-Cal Notice of Action, MC 239 SD. It informs client of the following:

- Appeal rights through SSA,
- Information regarding SSA reconsideration/reopening,
- Circumstances in which SP-DED cannot make an independent disability determination,
- Circumstances in which SP-DED is allowed to make an independent disability determination, and
- Circumstances in which client is allowed to file for a state hearing.

9. **MC 272 – SGA WORKSHEET**

This worksheet is used when applicant has gross earned income over the current SGA amount.

Section 1 Add gross average earnings. Include in-kind payments received, such as room and board (which is not condition of employment) and any other income such as tips.

Section 2 Compute allowable Impairment- Related Work Expenses (IRWE explained in detail in Article 22 C-1 –Determining SGA) and deduct from gross earnings.

Section 4 If applicant's work is subsidized (as specified in Article 22 C-1), indicate what subsidy is worth.

Section 5 "Net countable earnings" , after deductions, should be current SGA amount or less in order for case to be referred to SP-DAPD. If above current SGA amount client is performing SGA and ineligible for Disabled-MN.

10. MC 273 – WORK ACTIVITY REPORT (ENGLISH/ SPANISH)

Form is provided to applicant to inform him/her about the SGA limit. It gives applicant the opportunity to provide information leading to IRWE or subsidy deductions.

Items 1to 9 Applicant completes these items.

"Check List For County Use Only"

This is a check list for the EW to determine whether the applicant has any subsidies or IRWEs that can be deducted from gross wages. After the subsidies and IRWEs have been deducted, the EW indicates whether the applicant is engaging in SGA.

Space is provided if explanations are necessary.

11. MC 4033 – UPDATE TO DISABILITY LIAISON LISTS

CWD completes MC 4033 to notify the state of any updates needed for designated liaisons and mailing lists for either:

- MEDI-CAL LIAISON(S) FOR DISABILITY ISSUES, or
- MEDI-CAL LIAISON(S) FOR QUARTERLY STATUS LISTINGS FOR PENDING AND CLOSED DISABILITY CASES.

Check appropriate listings being changed. Specify items being updated. Complete a separate form for each representative and corresponding information being updated. Print or type the information. Send form to DHS-MEB.

12 DHS 7035A / DHS 7035 C – MEDICAL REPORT ON ADULT/CHILD WITH ALLEGATIONS OF HIV

DHS 7035A is used for an adult, and DHS 7035 C for a child, who alleges HIV, AIDS or ARC. These are completed by a medical source when client alleges having Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC). Upon receipt of form, CWD processes case under Presumptive Disability (PD) criteria.

Article 22 C-2 -- Determining Presumptive Disability discusses in detail how this form is used and evaluated.

13 DHS 7045 – WORKER OBSERVATIONS – DISABILITY

CWD staff should use form to record comments on an individual's physical , mental, and /or emotional problems. If DHS 7045 is not used to record observations, CWD should provide observations in Item 10, " County Worker Comments" section of MC 221. Article 22 C-4 – Providing CWD Worker Observations provides guidelines in assisting Ews in providing observations to SP-DAPD.

DHS 7045 may be submitted to SP-DAPD with the disability packet or at a later date, should EW have additional observations to provide.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION

SHOULD YOU APPLY FOR MEDI-CAL DISABILITY?

You should apply if you have a physical or mental condition that makes you unable to work for at least 12 months in a row.

Have you applied for and been denied Social Security disability or SSI in the past 12 months? If you have, you must tell your Eligibility Worker.

WHAT HAPPENS AFTER YOU HAVE APPLIED?

Usually, your disability claim will be sent to the Disability Evaluation Division (DED) of the State Department of Social Services. A disability analyst and a medical doctor will evaluate it. **Your Eligibility Worker does not have the authority to decide disability.**

- After the DED office receives your disability claim, they may contact you to get more information. If you get a letter, do what the letter says. Keep the letter and call the analyst named in the letter if you have questions about your disability claim.
- The DED office may contact you to arrange for a special medical exam. If you are asked to go to an exam, the exam is free to you and will be used to decide if you are disabled. Do not miss or cancel the exam.
- If you receive letters or phone calls from your disability analyst, answer right away.
- Tell your doctor(s) they may be contacted and that it will help if they send the requested information quickly.
- It is important that you quickly report any changes, especially in address or telephone number to your county Eligibility Worker. Your worker will send this information to the disability analyst. If you are homeless, be sure to keep in touch with your Eligibility Worker.
- Give your worker the phone number and address of a family member, friend, or other person who your worker can contact if you can't be reached.
- If it is decided that you are disabled, your county Eligibility Worker will contact you to get current information on your financial situation. **IT IS IMPORTANT THAT YOU PROVIDE THIS INFORMATION.**

MC 917 (10/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

LO QUE USTED DEBERIA SABER ACERCA DE SU SOLICITUD PARA MEDI-CAL BASADA EN INCAPACIDAD

¿DEBERIA USTED SOLICITAR MEDI-CAL BASADA EN INCAPACIDAD?

Usted debería solicitarla si tiene alguna condición física o mental que le impide trabajar por lo menos 12 meses seguidos.

¿Ha solicitado, y se le ha negado incapacidad del Seguro Social o SSI, en los últimos 12 meses? Si lo ha hecho, tiene que decírselo a su trabajador(a) de elegibilidad.

¿QUE SUCEDE DESPUES QUE USTED HAYA PRESENTADO LA SOLICITUD?

Normalmente, se enviará su solicitud para incapacidad a la División de Evaluación de Incapacidad (DED) del Departamento de Servicios Sociales del Estado. Un analista de incapacidad y un doctor en medicina la evaluarán. **Su trabajador de elegibilidad no tiene la autoridad de decidir si usted está incapacitado(a).**

- Una vez que la oficina de DED reciba su solicitud para incapacidad, es posible que ellos se comuniquen con usted para obtener más información. Si recibe una carta, haga lo que le dice la carta. Conserve la carta y llame al analista que se menciona en la carta si tiene preguntas con relación a su solicitud para incapacidad.
- La oficina de DED posiblemente se ponga en contacto con usted para hacer arreglos para que se haga un examen médico especial. Si le piden que vaya a que le hagan un examen, el examen no le cuesta a usted, y se usará para decidir si está incapacitado(a). No deje de ir al examen, ni lo cancele.
- Si recibe cartas o llamadas telefónicas de su analista de incapacidad, conteste de inmediato.
- Dígale a su doctor(es) que es posible que se pongan en contacto con él, y dígale que ayudará si envía de inmediato la información que se le pida.
- Es importante que usted reporte de inmediato cualesquier cambios, especialmente de dirección o de número de teléfono a su trabajador de elegibilidad del condado. Su trabajador enviará esta información al analista de incapacidad. Si no tiene hogar, asegúrese de mantenerse en contacto con su trabajador de elegibilidad.
- Dé a su trabajador el número de teléfono y la dirección de algún pariente, amistad, u otra persona con quien se pueda poner en contacto su trabajador, para en caso de que no se le pueda localizar a usted.
- Si se decide que usted está incapacitado, su trabajador de elegibilidad se comunicará con usted para obtener información al corriente sobre su situación económica. **ES IMPORTANTE QUE USTED PROPORCIONE ESTA INFORMACION.**

MC 017 (SP) (10/83) 33 2650

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
MEDI-CAL PROGRAM

DEPARTMENT OF HEALTH SERVICES
(County Address)

Date: _____
Case Name: _____
Case No.: _____
Worker Name: _____
District: _____

This letter is to tell you that all of the information necessary to refer your case to State Programs, Disability Evaluation Division for a disability determination has not been received.

Though federal law requires that eligibility for Medi-Cal based on disability be decided within 90 days, we are not able to do so in your case due to the reason(s) checked below.

We are awaiting the following information:

- ☐ For you to respond to our request for additional information (_____)
- ☐ For you to respond to our request to come into the office
- ☐ For you to contact your eligibility worker RIGHT AWAY because your disability form(s) is not completed correctly
- ☐ Other _____

_____

_____

If you have questions about your Medi-Cal application, call me at ( )_____ between _____ a.m. and _____ p.m.

MC 179 (4/83)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
MEDI-CAL PROGRAM

DEPARTMENT OF HEALTH SERVICES

(Direccion del Condado)

Fecha: _____

Nombre del Caso: _____

_____

No. del Caso: _____

Nombre del trabajador(a): _____

_____

Distrito: _____

Esta carta es para informarle que no se ha recibido toda la información necesaria para manejar su caso a los Programas del Estado. División de Evaluación de Incapacidad para llevar a cabo una determinación sobre incapacidad.

Aun cuando la ley federal requiere que se decida la elegibilidad para recibir Medi-Cal basada en incapacidad en un plazo de 90 días, no podemos hacerlo en el caso suyo debido a la(s) razón(es) marcada(s) enseguida.

Estamos esperando:

☐ que usted nos proporcione la información adicional que le pedimos (_____)

☐ que usted venga a nuestra oficina como se lo pedimos

☐ que usted se comunique con su trabajador de elegibilidad DE INMEDIATO porque su(s) forma(s) de incapacidad no está(n) llenada(s) correctamente

☐ Otro _____

_____

_____

Si tiene preguntas acerca de su solicitud para Medi-Cal, llámeme al ( ) _____ entre las _____ a.m. y las _____ p.m.

MC 179 (SP) (4/93)

State of California - Health and Welfare Agency — Department of Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
AUTORIZACION PARA PROPORCIONAR INFORMACION MEDICA

Name of Applicant/*Nombre del Solicitante* _____

Social Security Number/*Numero del Seguro Social* _____

I.D. Number/*Numero de Identificación* _____

(Hospital, Clinic, VA, or WCAB/*Hospital, Clínica, Administración de Veteranos, o WCAB*)

I authorize
Autorizo a _____

to disclose my medical records or other information for the period beginning _____ and ending _____
que revele mis antecedentes médicos u otra información sobre el período de Date/*Fecha* *a* Date/*Fecha*

to the state agency that will review my application for disability benefits under the Social Security Act.
a la dependencia estatal que revisará mi solicitud para beneficios por incapacidad bajo el Decreto del Seguro Social.

I authorize a private photocopy company to photocopy such medical records as are needed as evidence in determining my eligibility for such benefits. I have been informed that the private photocopy company will not release any information about me to any person or agency other than the state agency indicated above.

This consent can be withdrawn at anytime; however, it will remain valid for any action taken prior to the request being withdrawn. The duration of this consent shall not be any longer than is reasonably necessary to accomplish the purpose for which it was given, i.e., the final determination of my application for disability benefits (including the appeals process). This consent will then automatically expire without any written request.

I consent to the release of the results of any alcohol and/or drug abuse treatment, and/or psychiatric records under the same conditions as outlined above, and/or the human immunodeficiency virus (HIV) antibody test and any other indicators of immune status and medical records and information pertaining to the treatment of AIDS or ARC (AIDS-related complex). I understand that such information cannot be released without my specific consent, except in special circumstances.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have the right to receive a copy of this authorization on request.

Autorizo a un negocio privado de fotocopiado para que saque copias fotostáticas de los antecedentes médicos que sea necesario presentar como pruebas para determinar mi elegibilidad para tales beneficios. Se me informo que el negocio privado de fotocopiado no divulgara ninguna información mía a ninguna persona o dependencia que no sea la dependencia estatal que se indica arriba.

Este consentimiento puede ser retirado en cualquier momento; sin embargo, permanecera en vigor con respecto a cualquier accion que se haya ejercitado antes que se retirara la peticion. La vigencia de esta peticion, no durara más que lo razonablemente necesario para llevar a cabo el asunto para el cual se dio; esto es, la determinacion final de mi solicitud para beneficios de incapacidad (incluyendo el procedimiento de apelaciones). Entonces, este consentimiento expirara automaticamente sin pedirlo por escrito.

Autorizo que los resultados de la prueba para detectar cualesquier tratamientos relacionados con el abuso del alcohol y/o drogas, y/o los expedientes siquiátricos para que sean proporcionados bajo las mismas condiciones que se indican arriba, y/o los examenes de los anticuerpos del virus de inmunodeficiencia humana (VIH) *(HIV - human immunodeficiency virus)*, y cualesquier otros indicadores de la situación de inmunidad y antecedentes médicos e información relacionada con el tratamiento del SIDA (*AIDS*) o del complejo relacionado al SIDA (CRS) *(ARC - AIDS-related complex)*. Entiendo que tal información no puede proporcionarse a menos que de mi consentimiento expreso, excepto en circunstancias especiales.

He leído y entiendo perfectamente la información que aparece arriba. He hecho preguntas sobre dudas que tenía, y estoy satisfecho con las aclaraciones que me proporcionaron. Entiendo que tengo el derecho de recibir una copia de esta autorización, si así lo deseo.

_____ _____
Signature of Applicant/*Firma del Solicitante* Date/*Fecha*

_____ _____
Signature of Person Acting in Behalf/*Firma de la Persona que lo Representa* Date/*Fecha*

_____
Street Address/*Dirección*

_____ _____ _____
City/*Ciudad* ZIP Code/*Zona Postal* Telephone/*Teléfono*

To Whom it May Concern: Medical reports released to the state's Disability Evaluation program become part of the applicant's file subject to the provisions of the Federal Privacy Act of 1974 which provides that, upon request, an applicant may have access to those records. A condition of access to medical records is that, at the time access is requested, the applicant must designate a representative to receive, review, and discuss them with the applicant. It is recommended, but not required, that the representative be a physician or other health service professional.

A Quien Corresponda: Los expedientes medicos proporcionados a programa estatal de Evaluacion de Incapacidades (Disability Evaluation) forman parte del expediente del solicitante de acuerdo a lo estipulado por el Decreto Federal de Confidencialidad de 1974 que establece que el solicitante puede tener acceso a esos expedientes si así lo solicita. Una condicion para obtener acceso a los expedientes medicos sera que, al presentarse la solicitud, el solicitante tiene que nombrar a un representante para que los reciba, examine, y los repase con el solicitante. Es recomendable pero no obligatorio, que el representante sea un medico u otro profesional en el ramo de la salud.

MC 220 English/Spanish (7/83)

State of California—Health and Human Services Agency

Department of Health Ser

County Welfare Department Address

PLEASE PRINT

Retain Copy 4
(Send copies 1, 2, and 3 to DAPD)
DO NOT MAIL TO APPLICANT

County number | Aid code | Case number

DAPD Address

Los Angeles State Programs Branch
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030

1. Applicant name (first) (middle name) (last)

2. Social Security number
☐ Pending ☐ None

3. Date of birth
Month Day Year

4. Sex ☐ Male ☐ Female

5. Date applied
Month Day Year

6. List retro month(s)
Month/Year Month/Year Month/Year

7. Mailing address

8. Type of referral (check appropriate box(es))

- ☐ Initial referral
- ☐ Redetermination
- ☐ Reevaluation
- ☐ Pickle-blind
- ☐ Reexamination
- ☐ IHSS
- ☐ SGA IHSS
- ☐ SGA-disabled
- ☐ CAPI
- ☐ Resubmitted packet
- ☐ Retro-onset
- ☐ Limited referral
- ☐ Other—explain (item 10)

Telephone number: (area code)

9. Is applicant in a hospital? ☐ Yes ☐ No
Name of hospital:

10. County worker comment(s) (If more space is needed, attach a separate sheet.) ☐ See attached sheet (e.g., DHS 7045)

☐ (MC 179) 90-Day Status Letter attached ☐ Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number | Print worker name

Telephone number (area code) | FAX number (area code) | 12. Date sent Month Day Year

DAPD USE ONLY

13. ☐ See attached DAPD Documents (This is NOT a certification for in-home supportive services.)

Comment(s) or SP-DAPD Presumptive Disability decision

14. Analyst | 15. Date

16. Team manager | 17. Date

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4

☐ Oakland ☐ Los Angeles

MC 221 LA (1/00)

Due to the fact that items 5, 6, and 8 are frequently misunderstood, the following explanations are given:

Item 5: Date applied: For a new Medi-Cal applicant, enter the date that the SAWS 1 was signed. For a continuing case, enter the date that the disability was first reported to the county.

Item 6: List retro month(s): List all months for which applicant requests coverage during the retroactive period (not more than three months prior to any application date).

Item 8: Check all boxes that apply.

Initial Referral: Check this box to request first-time evaluation for disability or blindness. This is used for all initial referrals.

Redetermination: Check box if a beneficiary was previously determined to be disabled, was discontinued for a reason other than cessation of disability, AND (1) the last DAPD determination occurred 12 or more months in the past, *OR* (2) whose reexamination date is due/past due or unknown. Attach a copy of the prior MC 221.

Reevaluation: Check box if the county disagrees with DAPD's determination and is sending the case back for another review within 90 days of DAPD's decision. Reason for the disagreement must be explained in item 10. Attach a copy of the prior MC 221.

Pickle-Blind: Potentially blind individuals who are discontinued from SSI for any reason must be screened under the Pickle program (DHS 7020). Blindness evaluations for former SSI recipients for a determination under the Pickle Amendment to the Social Security Act may be necessary even if the individual has reached age 65 or has already been determined to be disabled. This is because blind individuals are entitled to a higher SSI payment level than disabled or aged persons.

Reexamination: Check box if a reexam date is due/past due or if an evaluation of a beneficiary's disability is needed to determine if medical improvement has occurred. Attach a copy of the prior MC 221.

IHSS: In Home Supportive Services. Check box if a disability evaluation is needed for an IHSS applicant.

SGA IHSS: Check box if an applicant's SSI benefits have been discontinued due to SGA and the applicant is in need of IHSS. In these DAPD evaluations, DAPD must confirm that the applicant's SSI benefit was discontinued due to SGA and prove that the impairment(s) for which SSI was allowed has not improved.

SGA Disabled: Substantial Gainful Activity (SGA). Check box if an applicant was an SSI disabled recipient, became ineligible for SSI because of SGA (gainful employment), and still has the medical impairment which was the basis of the SSI disability determination.

CAPI (Cash Assistance Program for Immigrants): This program provides cash assistance to aged, blind and disabled legal immigrants who meet the SSI immigration status requirements effective August 21, 1996, and all other current SSI eligibility requirements. If not aged (65 years of age or older), then disability/blindness must be established on an individual before CAPI payments can be made.

Resubmitted Packet: Check box if the original packet was received by DAPD and subsequently returned to the county for needed information, i.e., Z56 (no determination) or Z55 (county return for packet deficiency, upon resubmitting to DAPD, county should attach a copy of the SPB 105 letter which DAPD previously attached to the returned packet). The county will furnish the needed information and return the packet to DAPD as a Resubmitted Packet. Attach a copy of the prior MC 221.

Retro-Onset: Check box only if the beneficiary was previously determined to be disabled and the case is being resubmitted to evaluate for an earlier onset date. (Onset cannot be granted more than three months prior to application.) Attach a copy of the prior MC 221 to the packet. **For new referrals, *DO NOT* check this box; simply indicate the requested onset in item 6.**

Limited Referral: Appropriate under the following circumstances: (1) A reevaluation packet is sent back within 30 days of DAPD decision and no new treating source alleged; (2) an earlier onset is needed after DAPD approved case (no new treating sources are alleged during earlier onset period) and it is within 12 months of application; (3) client discontinued from SSI due to excess income/resource and not receiving Title II disability benefits; (4) application is made on behalf of deceased client and death certificate is included; or (5) county unable to verify SSI benefits and only verification for SSI benefits for IHSS is requested.

State of California—Health and Human Services Agency | Department of Health Servic

County Welfare Department Address

PLEASE PRINT

Retain Copy 4
(Send copies 1, 2, and 3 to DAPD)
DO NOT MAIL TO APPLICANT

County number | Aid code | Case number

DAPD Address

Oakland State Programs Branch
P.O. Box 23645
Oakland, CA 94623-9945

1. Applicant name (first) (middle name) (last)

2. Social Security number ☐ Pending ☐ None

3. Date of birth Month Day Year

4. Sex ☐ Male ☐ Female

5. Date applied Month Day Year

6. List retro month(s) Month/Year Month/Year Month/Year

7. Mailing address

8. Type of referral (check appropriate box(es))

- ☐ Initial referral
- ☐ Redetermination
- ☐ Reevaluation
- ☐ Pickle-blind
- ☐ Reexamination
- ☐ IHSS
- ☐ SGA IHSS
- ☐ SGA-disabled
- ☐ CAPI
- ☐ Resubmitted packet
- ☐ Retro-onset
- ☐ Limited referral
- ☐ Other—explain (item 10)

Telephone number: (area code)

9. Is applicant in a hospital? ☐ Yes ☐ No
Name of hospital:

10. County worker comment(s) (If more space is needed, attach a separate sheet.) ☐ See attached sheet (e.g., DHS 7045)

☐ (MC 179) 90-Day Status Letter attached ☐ Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number | Print worker name

Telephone number (area code) | FAX number (area code) | 12. Date sent Month Day Year

DAPD USE ONLY

13. ☐ See attached DAPD Documents (This is NOT a certification for in-home supportive services.)

Comment(s) or SP-DAPD Presumptive Disability decision

14. Analyst | 15. Date

16. Team manager | 17. Date

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4 ☐ Oakland ☐ Los Angeles

MC 221 OAK (1/00)

State of California—Health and Human Services Agency

Department of Health Services

DAPD PENDING INFORMATION UPDATE

COUNTY WELFARE DEPARTMENT ADDRESS

DAPD ADDRESS

Oakland State Disability and
Adult Programs Division
P.O. Box 23645
Oakland, CA 94623-0645

County Number	Aid Code	Case Number
	—	—

Social Security Number on MC 221 ____ — ____ — ____

Applicant's Name (Last, First, MI) _____

Date of Birth ____ — ____ — ____

THIS FORM MUST BE USED WHEN A DISABILITY PACKET IS PENDING AT DAPD AND CHANGED/ADDITIONAL INFORMATION NEEDS TO BE SUBMITTED TO DAPD (DO NOT USE MC 221 TO REPORT CHANGES OR TO UPDATE INFORMATION.).

Check the appropriate box or boxes and complete the information.

1. ☐ CHANGE OF ADDRESS
   New address: _____
2. ☐ CHANGE OF TELEPHONE NUMBER
   New telephone number: ( ) _____
3. ☐ CHANGE OF SOCIAL SECURITY NUMBER
   Corrected number: ____ — ____ — ____
4. ☐ CASE CLOSED
   Date: _____ (Discontinue evaluation)
5. ☐ CLIENT DECEASED
   Death certificate attached ☐ Yes ☐ No
6. ☐ NON-ENGLISH SPEAKING
   Language spoken: _____
   Interpreter name: _____ Phone number: ( ) _____
7. ☐ UPDATED MEDICAL RECORDS ATTACHED
8. ☐ CHANGE OF COUNTY WORKER (See below)
9. ☐ OTHER _____

Worker name (Please print)	Worker number
Date	Telephone number ( )

MC 222 OAK (3/02)

State of California—Health and Human Services Agency

Department of Health Services

DAPD PENDING INFORMATION UPDATE

COUNTY WELFARE DEPARTMENT ADDRESS

DAPD ADDRESS

Los Angeles State Disability and
Adult Programs Division
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030-9934

County Number	Aid Code	Case Number
	—	—

Social Security Number on MC 221 ____ — ____ — ____

Applicant's Name (Last, First, MI) ____

Date of Birth ____ — ____ — ____

THIS FORM MUST BE USED WHEN A DISABILITY PACKET IS PENDING AT DAPD AND CHANGED/ADDITIONAL INFORMATION NEEDS TO BE SUBMITTED TO DAPD (DO NOT USE MC 221 TO REPORT CHANGES OR TO UPDATE INFORMATION.).

Check the appropriate box or boxes and complete the information.

1. ☐ CHANGE OF ADDRESS
   New address: ____
2. ☐ CHANGE OF TELEPHONE NUMBER
   New telephone number: ( ) ____
3. ☐ CHANGE OF SOCIAL SECURITY NUMBER
   Corrected number: ____ — ____ — ____
4. ☐ CASE CLOSED
   Date: ____ (Discontinue evaluation)
5. ☐ CLIENT DECEASED
   Death certificate attached ☐ Yes ☐ No
6. ☐ NON-ENGLISH SPEAKING
   Language spoken: ____
   Interpreter name: ____ Phone number: ( ) ____
7. ☐ UPDATED MEDICAL RECORDS ATTACHED
8. ☐ CHANGE OF COUNTY WORKER (See below)
9. ☐ OTHER ____

Worker name (Please print)	Worker number
Date	Telephone number ( )

MC 222 LA (3/02)

State of California—Health and Welfare Agency | Department of Health Services

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

COUNTY USE ONLY
County Number/Aid Code/Case Number
— —

PART I—PERSONAL INFORMATION

1a. Applicant name (Last, First, MI)	1b. Social Security number	1c. Date of birth
	— —	/ /

1d. Other name(s) used (Last, First, MI)	1e. Sex	1f. Height	1g. Weight
	☐ Male ☐ Female	Feet ____ Inches ____	Pounds ____

2a. Home address	City	State	ZIP code

2b. Mailing address (if different)	City	State	ZIP code

3. Daytime telephone number	Check if:	Best time to call
(____) _____	☐ No Phone ☐ Message Phone (____) _____	

4a. Do you speak English?	4b. Do you have an interpreter?	If YES, interpreter's name:	Best time to call
☐ Yes If YES, go to Part II	☐ Yes ☐ No		
☐ No If NO, what language(s) do you speak: _____		Interpreter's phone number: (____) _____	

PART II—MEDICAL INFORMATION

COUNTY USE ONLY

5. Have you applied for Social Security Disability or Supplemental Security Income (SSI) Disability benefits in the past two (2) years? ☐ Yes ☐ No

If YES, please answer the following:

a. Was/Is your Social Security or SSI Disability application:

☐ Approved? ☐ Denied? ☐ Pending? ☐ On Appeal? ☐ Unknown?

b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application:

c. Has your medical problem(s) worsened since the date in 5b above? ☐ Yes ☐ No

If YES, please explain: _____

_____

d. Do you have any NEW medical problem(s) since the date in 5b, above, which you did NOT have when your Social Security or SSI disability decision was made?

☐ Yes ☐ No If YES, what medical problem(s)? _____

_____

6. List all medical problems (physical, mental or emotional) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

MC 223 (8/94)

7. Have you received care in a clinic or hospital for your illness(es) or injury(ies) in the last 12 months? ☐ Yes ☐ No

COUNTY USE ONLY

If YES, please fully answer the following:

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

MC 220 Signed ☐

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the emergency room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

8. List any additional clinic or hospital where you have been seen in the last 12 months.

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

MC 220 Signed ☐

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the emergency room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

If you have been seen at additional clinics or hospitals in the last 12 months, complete page 8.

MC 220 (Rev)

9. Have you been seen by any doctor outside of the clinic(s) or hospital(s) you have already listed in the last 12 months? ☐ Yes ☐ No

If NO, go to number 10. If YES, please fully answer the following, if more than one doctor was seen please complete page 8 for all additional information:

COUNTY USE ONLY

Name of doctor(s)

Patient/clinic or member number | Doctor's telephone number ( )

Address of doctor (number, street, suite) City State ZIP code

MC 220 Signed ☐

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. (IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST ONLY THE NAME AND DATE.)

TEST PERFORMED	YES	NO	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)	
Electrocardiogram (EKG)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Treadmill (exercise heart test)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Chest X-ray			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Breathing Test (PFT)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Blood Tests			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Other (Specify)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐

MC 220 (8/94)

11. Have you had any other medical treatment or testing in the past 12 months? ☐ Yes ☐ No

If NO, go to number 12.
If YES, complete page 8.

COUNTY USE ONLY

12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? ☐ Yes ☐ No

If YES, please list below:

Name

Address (number, street, suite)

Telephone number ( ) | Relationship to you

Name

Address (number, street, suite)

Telephone number ( ) | Relationship to you

Name

Address (number, street, suite)

Telephone number ( ) | Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

Are you willing to go to additional medical examinations if needed? ☐ Yes ☐ No

PART III—SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

15. Describe your educational background.

a. Check the highest grade you finished in school:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

☐ 12 or ☐ GED (same as finishing 12th grade) ☐ 12+

b. When finished? Month/year: _____

c. Did you take special education classes? ☐ Yes ☐ No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

☐ Yes ☐ No

If NO, skip Part IV, go to Part V, page 7, for your signature.

If YES, answer Part IV, page 5, beginning with number 17.

PART IV—WORK HISTORY

COUNTY USE ONLY

17. Describe all of the jobs you have done for at least 30 days during the last 15 years. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a. Job title | Type of business

Dates worked (month/year) From: _____ To: _____ | Hours per week | Rate of pay | Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).
I wrote, completed reports, or performed similar duties: ☐ Yes ☐ No
I had supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY — **Circle One**

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

I bent over this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Heaviest weight I lifted: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs
I often lifted/carried up to: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ☐ Yes ☐ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, go to 17b, next page. If YES, please complete the following information.

Name of medical problem(s): _____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ☐ Yes ☐ No

If YES, when? Month _____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ☐ Yes ☐ No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

MC 223 (8/94)

17. b. Job title | Type of business

Dates worked (month/year): From: _____ To: _____ | Hours per week | Rate of pay | Per hour/wk/mo

DESCRIPTION OF THE JOB (This is what I did and how I did it)

These are the tools, machines, and equipment I used:

I took this long to learn the job: _____ day(s) or _____ month(s).
I wrote, completed reports, or performed similar duties: ☐ Yes ☐ No
I had supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY — Circle One

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

I bent over this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Heaviest weight I lifted: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs
I often lifted/carried up to: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ☐ Yes ☐ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, ask your county worker for additional pages. If YES, please complete the following information.

Name of medical problem(s): _____

Did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ☐ Yes ☐ No

If YES, when? Month _____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ☐ Yes ☐ No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

PART V—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Supplemental Statement of Facts is true and correct.

Signature of Applicant ▶	Date
Signature of Witness (If applicant signed with a mark) ▶	Date
Signature of person helping applicant fill out the form ▶	Date

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

Continued answer(s) to question(s) number 8 on page 2, number 9 on page 3, and number 10 on page 3. If you need more room, please ask your county worker for additional pages to complete.

COUNTY USE ONLY

List any additional clinic or hospital where you have been seen in the last 12 months:

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number: ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) | City | State | ZIP code

MC 220 Signed ☐

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the hospital overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the emergency room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

List any additional doctor you saw outside of the clinic(s) or hospital(s) you have already listed:

Name of doctor(s)

Patient/clinic or member number | Doctor's telephone number ( )

Name of doctor(s) seen

ADDRESS of doctor (number, street, suite) | City | State | ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

MC 220 Signed ☐

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

List any additional tests you have had in the last 12 months:

TEST PERFORMED	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST(S) WAS COMPLETED.	DATE (MO/YR)
	Name Address (number, street, suite) City State ZIP code	
	Name Address (number, street, suite) City State ZIP code	

MC 220 Signed ☐

MC 220 Signed ☐

MC 220 (8/94)

State of California - Health and Welfare Agency
Medi-Cal Program

Department of Health Services

MEDI-CAL NOTICE OF ACTION DENIAL OF BENEFITS DUE TO A FEDERAL SOCIAL SECURITY DISABILITY DETERMINATION

(County Stamp)

Case No.: _____

District: _____

Denial for: _____

_____
(Names)

Your application for Medi-Cal dated _____ has been denied.

You have been denied because of the following reasons:

Federal disability rules do not allow us to make a separate disability determination if any of the conditions below apply to you. The State must use the Social Security Administration's (SSA) disability determination under the conditions listed below.

The State has no authority to review your disability status if SSA denied your SSA and/or SSI disability claim through the SSA medical review process.

AND

You claim the same disabling condition considered by SSA.

OR

Your Medi-Cal application based on disability is within 12 months of the date that SSA and/or SSI determined that you were not disabled, and you now claim that your condition has gotten worse or changed.

Because your disabling condition has worsen, you MUST contact your local SSA office for your case to be reconsidered or reopened. (SEE SSA APPEAL RIGHTS ON ADDITIONAL PAGE.)

(If SSA REFUSES to reconsider or reopen your case, you may come back to the county and reapply for Medi-Cal.)

(You may also apply for Medi-Cal if SSI denied/discontinued your claim for reasons other than disability.)

This section is required by Title 42 of the Code of Federal Regulations, Part 435 and California Code of Regulations, Title 22, Sections 50005, 50006, 50167 and 50223.

IF YOU BELIEVE THAT THE DECISION TO DENY YOU THE RIGHT TO FILE A MEDI-CAL APPLICATION WAS INCORRECTLY MADE, PLEASE SEE THE BACK OF THIS NOTICE REGARDING YOUR RIGHTS TO APPEAL THIS ACTION WITH THE STATE

_____ (Eligibility Worker) _____ (Phone) _____ (Dated)

MC 239 SD (3/92)

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

BLACK

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

NOTIFICACION DE ACCION DE MEDI-CAL
NEGACION DE BENEFICIOS DEBIDO A UNA DETERMINACION FEDERAL DE INCAPACIDAD DE LA ADMINISTRACION DEL SEGURO SOCIAL

(Sello del Condado)

No. del Caso: _____

Distrito: _____

Negación para: _____

_____
(Nombres)

Su solicitud para Medi-Cal de fecha _____ha sido negada.

Se le ha negado debido a las siguientes razones:

Las normas federales sobre incapacidad no nos permiten hacer una determinación de incapacidad por separado si alguna de las condiciones siguientes, es pertinente a usted. El estado tiene que utilizar la determinación de la Administración del Seguro Social (SSA) sobre incapacidad bajo las condiciones enumeradas enseguida.

El estado no tiene la autoridad de hacer una revisión de la incapacidad suya si la SSA negó su reclamo para incapacidad de la SSA y/o el SSI, a través del proceso de revisión médico de la SSA.

Y

Usted alega la misma condición incapacitante que ya tomó en consideración la SSA.

O

Su solicitud para Medi-Cal con base en incapacidad cae dentro de los 12 meses contados a partir de la fecha en que la SSA y/o el SSI determinó que usted no estaba incapacitado, y ahora usted alega que su condición ha empeorado o ha cambiado.

Ya que su condición ha empeorado, usted TIENE QUE ponerse en contacto con su oficina local de la SSA para que vuelvan a considerar su caso, o para que lo vuelvan a abrir. (VEA LOS DERECHOS DE APELACION EN LA SSA EN LA PAGINA ADICIONAL.)

(Si la SSA SE REHUSA a volver a considerar o a abrir el caso suyo, puede regresar a la oficina del condado para volver a solicitar Medi-Cal.)

(También puede solicitar Medi-Cal si el SSI negó/descontinuó su reclamo por razones diferentes a la incapacidad.)

Esta sección la requiere el Título 42 del Código de Ordenamientos Federales, Parte 435, y Título 22, secciones 50005, 50006, 50167 y 50223 del Código de Ordenamientos de California.

SI USTED CREE QUE LA DECISON DE NEGARLE EL DERECHO A PRESENTAR UNA SOLICITUD PARA MEDI-CAL FUE INCORRECTA, POR FAVOR VEA EL REVERSO DE ESTA NOTIFICACION PARA ENTERARSE DE SU DERECHO A APELAR CON EL ESTADO ESTA ACCION

_____ (Trabajador de Elegibilidad) _____ (Teléfono) _____ (Fecha)

MC 239 SD (SP) (9/92)

SUS DERECHOS A UNA AUDIENCIA

Para pedir una audiencia con el estado.

El lado derecho de esta página le indica como hacerlo.

- Usted tiene solamente 90 días para solicitar una audiencia.
- Los 90 días comienzan [illegible] le enviamos esta notificación.
- Tiene menos tiempo para pedir una audiencia si desea seguir recibiendo los mismos beneficios.

Para conservar sus mismos beneficios mientras espera una audiencia

Debe solicitar una audiencia antes que la acción entre en vigor.

- Su asistencia monetaria permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Su Medi-Cal permanecerá sin cambios hasta que se lleve acabo su audiencia.
- Sus estampillas para comida permanecerán sin cambios hasta que se lleve a cabo la audiencia o hasta el fin de su período de certificación; lo que ocurra primero.
- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos debera cualesquier dinero o estampillas para comida que haya recibido.

Para que se descontinúen ahora sus beneficios

Si usted desea que se descontinúen su asistencia monetaria o sus estampillas para comida mientras espera una audiencia, marque uno de los casilleros.

☐ Asistencia monetaria ☐ Estampillas para comida

Para que le asistan

Puede obtener informacion acerca de sus derechos a una audiencia o asesoria legal gratuita llamando al teléfono de información del estado.

Número gratuito	1-800-952-5253
Si es sordo y usa TDD:	1-800-952-8349

Si no desea venir a la audiencia solo, puede traer un amigo, un abogado o cualquier otra persona, pero usted debe hacer los arreglos para traer a esa otra persona.

Es posible que pueda obtener ayuda legal gratuita en su oficina local de asesoramiento legal (legal aid) o de su grupo de derechos de recipientes de asistencia pública.

Otra Información

Mantenimiento de hijos: La oficina del Fiscal del Distrito le ayudará a cobrar mantenimiento de hijos aun cuando no esté recibiendo asistencia monetaria. Esta asistencia es gratuita. Si en la actualidad están cobrando mantenimiento de hijos a su nombre, ellos continuarán haciéndolo hasta que usted les dé aviso por escrito indicándoles que paren. Le enviarán a usted cualesquier cantidades de mantenimiento que cobren. Se quedarán con las cantidades vencidas cobradas que se le deban al condado.

Planificación familiar: Su oficina de bienestar le proporcionará información cuando usted la solicite.

Expediente de la audiencia: Si usted solicita una audiencia, la oficina de audiencias con el estado formara un expediente. Usted tiene el derecho de examinar este expediente. El Estado puede dar su expediente al departamento de bienestar, al Departamento de Salud y Servicios Humanos de los Estados Unidos y al Departamento de Agricultura de los Estados Unidos. (Seccion 10950 del Código de Bienestar e Instituciones)

[illegible]

COMO PEDIR UNA AUDIENCIA CON EL ESTADO

La mejor manera de solicitar una audiencia es llenar esta pagina y enviarla a:

También puede llamar al 1-800-952-5253.

PETICION PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción ejercitada por el Departamento de Bienestar del Condado de _____ acerca de mi:

☐ Asistencia monetaria ☐ Estampillas para Comida

☐ Medi-Cal

☐ Otro (anote)_____

La razón es la siguiente: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

La siguiente persona vendrá conmigo a la audiencia a ayudarme (nombre y dirección si los sabe):

_____

_____

_____

Necesito un interprete sin costo para mí.

Mi idioma es el: _____

Mi nombre: _____

Dirección: _____

_____

Teléfono: _____

Mi Firma: _____

Fecha: _____

State of California - Health and Welfare Agency | Department of Health Services

IMPORTANT INFORMATION REGARDING YOUR APPEAL RIGHTS

SOCIAL SECURITY INFORMATION

Your Right To Appeal Through Social Security

If you disagree with the Social Security Administration (SSA) disability determination, you can ask that the determination be reviewed by either requesting a reconsideration or a reopening of your case. If you want a **reconsideration, you must ask for it within 60 days from the date you received the notice from Social Security that denied your application for SSI (Supplemental Security Income) or Disability Benefits. If more than 60 days have gone by from such date, you must give a good reason for the delay.** You may also file a new application at any time.

Your request must be made in writing through any SSA office. Be sure to tell them your name, Social Security number and why you disagree with the determination. Also tell them the date you were denied Medi-Cal by California. **If you have any questions as to how to file your request with Social Security, call your local SSA office immediately.** If you visit your Social Security office, please take this notice with you.

STATE OF CALIFORNIA INFORMATION

Regarding Your Medi-Cal Disability Status

The State has no authority to review your disability status if:

(1) you are claiming the same disabling condition which SSA considered and your condition has NOT gotten worse, NOT changed or you have NO new disabling condition;
(2) you are claiming the same disabling condition which SSA considered and your condition has changed or gotten worse; **AND**
(3) there was an SSA disability determination made within 12 months of the disability based Medi-Cal application, and SSA has NOT refused to reopen your case.

If you feel that the decision to deny you the right to file a disability based Medi-Cal application was incorrect, you should contact your local welfare office. Listed in (1) and (2) below are possible reasons which may allow you to apply for Medi-Cal based on disability.

(1) The disabling condition that you are reporting is new and different from the one considered by SSA.
(2) Your Medi-Cal application is within 12 months of the date of the SSA disability denial and your condition has changed or gotten worse and either:
   (a) SSA has refused to accept your request to reopen your case;
   OR
   (b) you no longer meet the income and resource requirements of SSI but you may meet the income and resource requirements of Medi-Cal.

State Hearing Right On Issues Other Than Your Disability

Though the State may not have the right or authority to give you a hearing on your disability status (except see reasons under **"If you feel that the decision..." above**), you do have a right to a state hearing regarding your eligibility for Medi-Cal if:

(1) there are minor children who live in the home who are deprived of parental care and support;
(2) you are under 21 years of age or 65 years of age or older;
(3) you are pregnant;
(4) you live in a nursing home, or;
(5) you are a refugee.

If you wish to file a state hearing, you may do so on the back of a Notice of Action.

MC INFORMATION NOTICE 13 (3/92)

INFORMACION IMPORTANTE ACERCA DE SUS DERECHOS DE APELACION
INFORMACION CON RESPECTO AL SEGURO SOCIAL

Sus Derechos de Apelación por Medio del Seguro Social

Si usted no está de acuerdo con la determinación hecha por la Administración del Seguro Social (SSA) con respecto a la incapacidad, puede pedir que se vuelva a tomar en consideración su caso, o que se vuelva a abrir. **Si desea que se vuelva a tomar en consideración su caso, tiene que pedirlo en un plazo de 60 días contados a partir de la fecha en que usted reciba la notificación del Seguro Social indicando que han negado su solicitud para SSI (Seguridad de Ingreso Suplemental) o Beneficios de Incapacidad. Si pasan más de 60 días de tal fecha, deberá dar una razón justificada por su retraso.** También puede presentar una nueva solicitud en cualquier momento.

Tiene que presentar su petición por escrito a través de cualquier oficina de la SSA. Asegúrese de darles su nombre, su número del Seguro Social, y decirles por qué no está de acuerdo con la determinación. También dígales la fecha en que el Estado de California le negó el Medi-Cal. **Si tiene preguntas acerca de cómo presentar su petición al Seguro Social, llame de inmediato a su oficina de la SSA.** Si visita su oficina del Seguro Social, por favor lleve consigo esta notificación.

INFORMACION DEL ESTADO DE CALIFORNIA

Con Respecto a la Situación Suya Tocante al Medi-Cal Basado en Incapacidad

El Estado no tiene la autoridad para revisar la situación suya con respecto a incapacidad si:

(1) usted reclama la misma condición incapacitante que la SSA ha tomado en consideración, y su condición NO ha empeorado, NO ha cambiado, o usted NO tiene una condición nueva que le incapacite;
(2) usted está reclamando la misma condición incapacitante que ya tomó en consideración la SSA y su condición ha cambiado o ha empeorado; Y
(3) la SSA tomó una determinación en los últimos 12 meses contados a partir de la fecha en que se presentó la solicitud para Medi-Cal con base en incapacidad, y la SSA NO se ha rehusado a volver a abrir su caso.

Si usted cree que la decisión de negarle el derecho de presentar una solicitud para Medi-cal con base en incapacidad fue incorrecta, debería ponerse en contacto con su oficina local de bienestar. En seguida, en los números (1) y (2), se enumeran las posibles razones que pudieran permitir solicitar Medi-Cal con base en incapacidad.

(1) La condición incapacitante que usted está reportando es nueva y diferente de la que tomó en consideración la SSA.
(2) No han pasado 12 meses desde la fecha en que la SSA negó su solicitud para Medi-Cal, y su condición ha cambiado o empeorado, y ya sea que:
    (a) la SSA se ha rehusado a aceptar su petición para volver a abrir su caso; o
    (b) usted ya no reúne los requisitos de ingresos y recursos para recibir SSI, pero posiblemente reúna los requisitos de ingresos y recursos para recibir Medi-Cal.

Derecho a una Audiencia con el Estado con Respecto a Asuntos Diferentes a su Incapacidad

Aunque el Estado tal vez no tenga el derecho, o la autoridad de otorgarle una audiencia con relación a la situación de su incapacidad (**exceptuando las razones bajo "Si usted cree que la decisión..." de arriba**), usted tiene el derecho a una audiencia con el estado con respecto a su elegibilidad para recibir Medi-Cal si:

(1) hay hijos menores de edad que viven en el hogar, que están privados del cuidado y mantenimiento de sus padres;
(2) usted es menor de 21 años de edad o tiene 65 años de edad o más;
(3) usted está embarazada;
(4) usted vive en un establecimiento de cuidado continuo no intenso, o;
(5) usted es un(a) refugiado(a).

Si desea pedir una audiencia con el estado, puede hacerlo en el reverso de una Notificación de Acción.

MC INFORMATION NOTICE 13 (SP) (3/92)

State of California—Health and Human Services Agency | Department of Health Services

Name of disabled person	Social security number

SGA WORK SHEET

(Used when gross earned* income is over the current SGA amount.)

1. Earned Income
   a. Gross average monthly earnings $_____
   b. Payment in kind (e.g., room and board) which is *not* a condition of employment (use current market value) _____
   c. Other _____
   d. **TOTAL GROSS EARNINGS** (add a, b, and c) $ _____
2. Impairment-Related Work Expenses (IRWEs) (see MEPM, Article 22, 22C-2)
   a. Attendant care services $_____
   b. Transportation costs _____
   c. Medical devices _____
   d. Work-related equipment _____
   e. Prosthesis _____
   f. Residential modifications _____
   g. Routine drugs and routine medical services _____
   h. Diagnostic procedures _____
   i. Nonmedical applications and devices _____
   j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   k. Other items and services _____
3. **TOTAL IRWEs:** Add (total of 2a through 2k) $ _____
4. **TOTAL SUBSIDY** (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) (from MC 273, number 7) $ _____
5. **NET COUNTABLE EARNINGS** (subtract 3 and 4 from 1d) $ _____

- Are current countable earnings greater than $ _____? ☐ Yes ☐ No
  (Insert current SGA amount)
- If the answer is No, send a disability referral to SP-DAPD. In Item 10 of the MC 221, Disability Determination and Transmittal, write in "No SGA issue." Attach copy of MC 272 to the MC 221.
- If the answer is Yes, the client is engaging in SGA. Deny the disability claim. (Evaluate client for the Working Disabled Program.)

*NOTE: Income information obtained from completed MC 273 (Work Activity Report).

Eligibility Worker signature	Worker number	Date completed

MC 272 (8/01)

State of California—Health and Human Services Agency

Department of Health Services

WORK ACTIVITY REPORT

This report is for:	
Month	Year

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your gross earnings are more than $_____ *(current SGA amount)* per month, you might not be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the earnings limit. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your case. Your employer may be contacted to verify the information you provide.

Name of disabled person			Social security number	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From:_____ To:_____	
Employer's name			Employer's telephone number ( )	
Employer's address (number, street)	City		State	ZIP Code
Title or name of your job	Rate of pay	Hours worked per week	Dates worked (month/year) From:_____ To:_____	

1. **Gross Earning**—What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2. **Other Payments**—Specify other payments you receive, such as tips, free meals, room, or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **Special Employment Situations**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **Job Requirements**—Are your job duties listed below different from those of other workers with the same job title?

	Yes	No
a. Shorter hours	☐	☐
b. Different pay scale	☐	☐
c. Less or easier duties	☐	☐
d. Extra help given	☐	☐
e. Lower production	☐	☐
f. Lower quality	☐	☐
g. Other differences (e.g., frequent absences)	☐	☐

5. **Explanation of Job Requirements**—Describe all "yes" answers in item 4 on page 1.

MC 273 (8/01)

6. **Special Work Expenses**—Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

   Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

   Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, assistants (e.g., if visually impaired, the cost to hire a reader; if hearing impaired, the cost to hire a sign language interpreter), or similar items or services.

   _____

   _____

7. **Subsidies**—Some employers will support disabled individuals with subsidies. For example, the employer may subsidize the disabled employee's earnings by paying more in wages than the reasonable value of the actual work that was done. (For example, many sheltered work centers subsidize an individual's earnings.)

   Does your employer provide you with subsidies? ☐ Yes ☐ No

   If yes, please (a) tell us how much the subsidy is worth and (b) explain the type of subsidy that was given.

   a. $_____

   b. Explanation of subsidy: _____

   _____

   _____

8. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

   _____

   _____

   _____

   _____

9. Please read the following statement. Sign and date the form. Provide address and telephone number.

   If my employer should need to be contacted, this also authorizes my employer to disclose any information necessary for the county to evaluate my work activity for my Medi-Cal application based on disability.

   I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of applicant or representative	Date	Area code and telephone number
		( )

Mailing address (number, street, apartment number, P.O. box number, or Rural Route)

City	County	State	ZIP code

CHECKLIST FOR COUNTY USE ONLY

1. Enter amount of client's gross wages. $_____

   Does the client have any of the following deductions?

   a. Subsidy (see MEPM, Article 22, 22C-2.7) ☐ Yes ☐ No If yes, enter amount: $_____

   b. Impairment-related work expenses (IRWEs) ☐ Yes ☐ No If yes, enter amount: $_____

2. Add a and b above and subtract total from number 1. Is the remainder over the current SGA amount? ☐ Yes ☐ No
   If yes, client is engaging in SGA. If any explanations are needed, please use the following space:

_____

_____

_____

Eligibility Worker signature	Worker number	Date completed

MC 273 (8/01)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY — DEPARTMENT OF HEALTH SERVICES

INFORME DE ACTIVIDAD LABORAL

Es posible que se le considere incapacitado(a) para Medi-Cal, si usted no puede hacer ninguna clase de trabajo para el cual esta capacitado, y solamente si usted no puede trabajar durante por lo menos un año o si su condición le ocasionara la muerte.

Si sus ingresos son de más de $500 dólares al mes, en general a usted no se le puede considerar incapacitado. Los gastos de trabajo y consideraciones especiales de trabajo relacionados a su incapacidad se pueden deducir al calcular si sus ingresos cumplen con los límites de ingresos de $500. Por esta razón, se necesita la información acerca de su actividad laboral.

La información que usted proporcione acerca de su actividad laboral se utilizara al tomar una decisión sobre su reclamo. Es posible que nos comuniquemos con su patrono para comprobar la información que usted proporciona.

Nombre de la persona incapacitada		Numero del Seguro Social
1 Nombre del patrono	Direccion del patrono	No. de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana
2 Nombre del patrono	Direccion del patrono	No de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana

1. **INGRESOS BRUTOS GANADOS**

¿Cuál es su pago mensual bruto? (Si el pago es irregular, no necesita anotar la cantidad.) Adjunte sus talones de cheques.

2 **OTROS PAGOS**

Especifique otros pagos que usted reciba, tales como propinas, alimentos gratuitos, servicios públicos y municipales de cuarto. Indique lo que se le dio y calcule el valor actual y con qué frecuencia los recibe.

3. SITUACIONES ESPECIALES DE EMPLEO	Si	No
Después de enfermarse, ¿se aminoraron sus obligaciones de trabajo?	☐	☐
Si la respuesta es sí, ¿mantuvo el mismo pago?	☐	☐
¿Es usted empleado(a) de un amigo o pariente?	☐	☐
¿Está usted en un programa especial de capacitación o rehabilitación?	☐	☐

4. **REQUISITOS DE EMPLEO**

¿Son sus obligaciones de empleo diferentes a aquellas de otros trabajadores con el mismo puesto?

		Si	No
a.	horario más corto	☐	☐
b.	escala de pago diferente	☐	☐
c.	menos obligaciones o más fáciles	☐	☐
d.	se le proporciona ayuda adicional	☐	☐
e	producción mas baja	☐	☐
f	calidad más baja	☐	☐
g.	otras diferencias (ej.: faltas frecuentes)	☐	☐

MC 273 (SP) (1/94)

5. **EXPLICACION DE LOS REQUISITOS DE EMPLEO**

Describa todas las respuestas "afirmativas" en el articulo 4 anterior.

6. **GASTOS ESPECIALES DE TRABAJO**

A continuación, especifique cualesquier gastos especiales relacionados a su condición que son necesarios para usted para trabajar. Estos son cosas por las que usted pagó y no cosas que alguien más pagará.

Especifique la cantidad de gastos. Adjunte comprobantes de quién le recetó el articulo o servicio necesario y el costo pagado. (Se nos exige comprobar la necesidad del articulo o servicio con la persona que lo recetó.)

Ejemplo: Servicios de cuidador, costos de transporte, aparatos médicos, equipo relacionado al trabajo, protesis, modificaciones a su casa, medicamentos de rutina y servicios médicos necesarios para controlar una condición incapacitante, procedimientos de diagnóstico, o articulos o servicios semejantes.

7 Utilice este espacio adicional para contestar cualquier pregunta previa o para dar información adicional que usted piense que será útil.

8 Por favor, lea la siguiente declaración. Firme y feche la forma. Proporcione la direccion y el número de teléfono.

He completado esta forma correcta y verdaderamente segun mi leal conocimiento y habilidades.

Firma del Solicitante o Representante	Fecha	Area y No. de Teléfono

Dirección Postal (Número y Calle, No. de Apt., Apartado Postal o Ruta Rural)

Ciudad y Estado	Zona Postal	Condado

SOLO PARA USO DEL CONDADO

9 Interviewer/Reviewer Check List ("Yes" answers should be explained below.) Check all that apply:

a. Subsidy ☐ Yes ☐ No

b. Impairment-Related Work Expenses ☐ Yes ☐ No

c. Substantial Gainful Activity ☐ Yes ☐ No

EXPLANATION: _____

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 273 (SP) (3/94) Page 2 of 2

State of California—Health and Human Services Agency | Department of Health Services

DISABILITY LISTING UPDATE

Please indicate which list is to be updated with a check mark

☐ Medi-Cal liaison(s) for disability issues.

☐ Medi-Cal liaison(s) for quarterly status listings for pending and closed disability cases.

Please use this form to transmit the name of your county's representative, or in counties where multiple contacts will be necessary, please provide the same information for each representative on a separate form. It would be appreciated if the information is printed or typed

County	Liaison		
Liaison's position title	Liaison's telephone number ( )	Alternative telephone number ( )	
Office address (number, street)	City	State	Zip code

RETURN TO: Department of Health Services
Medi-Cal Eligibility Branch
Attn: Disability Liaison Coordinator
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

MC 4033 (2/05)

State of California—Health and Human Services Agency | Department of Health Services

DISABILITY LISTING UPDATE

Please indicate which list is to be updated with a check mark

☐ Medi-Cal liaison(s) for disability issues.

☐ Medi-Cal liaison(s) for quarterly status listings for pending and closed disability cases

Please use this form to transmit the name of your county's representative, or in counties where multiple contacts will be necessary, please provide the same information for each representative on a separate form. It would be appreciated if the information is printed or typed:

County	Liaison		
Liaison's position title	Liaison's telephone number ( )	Alternative telephone number ( )	
Office address (number, street)	City	State	Zip code

RETURN TO: Department of Health Services
Medi-Cal Eligibility Branch
Attn: Disability Liaison Coordinator
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

MC 4033 (2/05)

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 A
(Medical Report on Adult With Allegation of Human Immunodeficiency Virus [HIV] Infection)

Your patient, identified in Section A of the attached form, has filed a claim for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Services medical release (MC 220) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS complete Section B.**
- **Complete Section C, if appropriate.** If you check at least one of the items in Section C, go right to Section E.
- **ONLY complete Section D if you have NOT checked any item in Section C.** See the special information section below which will help you to complete Section D.
- **Complete Section E if you wish to provide comments on your patient's condition(s).**
- **ALWAYS complete Sections F and G. NOTE:** This form is not complete until it is signed.

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Repeated" Manifestations of HIV Infection *(see Item D.1)*:

"Repeated" means that a condition or combination of conditions:

- Occurs an average of three times a year, or once every four months, each lasting two weeks or more; or
- Does not last for two weeks, but occurs substantially more frequently than three times in a year or once every four months; or
- Occurs less often than an average of three times a year or once every four months but lasts substantially longer than two weeks.

What We Mean By "Manifestations of HIV Infection *(see Item D.1)*:

"Manifestations of HIV Infection" may include:

- Any conditions listed in Section C, but without the findings specified there, (e.g., carcinoma of the cervix not meeting the criteria shown in Item 22 of the form, diarrhea not meeting the criteria shown in Item 33 of the form); or any other condition that is not listed in Section C, (e.g., oral hairy leukoplakia, myositis).
- Manifestations of HIV must result in significant, documented symptoms and signs, (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

DHS 7035 A (Continued) (4/94) Continued on reverse →

What We Mean By "Marked" Limitation or Restriction in Functioning *(see Item D.2)*:

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

What We Mean By "Activities of Daily Living" *(see Item D.2)*:

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

  Example: An individual with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

What We Mean By "Social Functioning" *(see Item D.2)*:

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.

  Example: An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty in maintaining social functioning.

What We Mean By "Completing Tasks in a Timely Manner" *(see Item D.2)*:

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.

  Example: An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT NOTICE

The Department of Health Services (DHS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHS as follows: (1) to enable a third party or agency to assist DHS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 139a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

DHS 7035 A(Continued) (4/94)

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

Applicant's Signature (Required only if Form MC 220 is NOT attached) ➤	Date

A. IDENTIFYING INFORMATION:

Medical Source's Name	Applicant's Name
Applicant's Social Security Number	Applicant's Date of Birth

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable):

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

7. ☐ **Aspergillosis**
8. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
9. ☐ **Coccidioidomycosis,** at a site other than the lungs or lymph nodes
10. ☐ **Cryptococcosis,** at a site other than the lungs, (e.g., cryptococcal meningitis)
11. ☐ **Histoplasmosis,** at a site other than the lungs or lymph nodes
12. ☐ **Mucormycosis**

PROTOZOAN OR HELMINTHIC INFECTIONS:

13. ☐ **Cryptosporidiosis, Isosporiasis, or Microsporidiosis,** with diarrhea lasting for one month or longer
14. ☐ **Pneumocystis Carinii Pneumonia or Extrapulmonary Pneumocystis Carinii Infection**
15. ☐ **Strongyloidiasis,** extra-intestinal
16. ☐ **Toxoplasmosis,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS:

17. ☐ **Cytomegalovirus Disease,** at a site other than the liver, spleen, or lymph nodes
18. ☐ **Herpes Simplex Virus,** causing mucocutaneous infection, (e.g., oral, genital, perianal) lasting for one month or longer; or infection at a site other than the skin or mucous membranes, (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **Herpes Zoster,** disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **Progressive Multifocal Leukoencephalopathy**
21. ☐ **Hepatitis,** resulting in chronic liver disease manifested by appropriate findings, (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

SECTION C (continued)

MALIGNANT NEOPLASMS:

22. ☐ **Carcinoma of the Cervix,** invasive, FIGO stage II and beyond

23. ☐ **Kaposi's Sarcoma,** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

24. ☐ **Lymphoma,** of any type, (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)

25. ☐ **Squamous Cell Carcinoma of the Anus**

SKIN OR MUCOUS MEMBRANES:

26. ☐ **Conditions of the Skin or Mucous Membranes,** with extensive fungating or ulcerating lesions not responding to treatment, (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES:

27. ☐ **Anemia** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every two months

28. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

29. ☐ **Thrombocytopenia,** with platelet counts repeatedly below 40,000/mm^3 with at least 1 spontaneous hemorrhage, requiring transfusion in the last 5 months; or with intracranial bleeding in the last 12 months.

NEUROLOGICAL ABNORMALITIES:

30. ☐ **HIV Encephalopathy,** characterized by cognitive or motor dysfunction that limits function and progresses

31. ☐ **Other Neurological Manifestations of HIV Infection,** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME:

32. ☐ **HIV Wasting Syndrome,** characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of 1 month or longer

DIARRHEA:

33. ☐ **Diarrhea,** lasting for one month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

34. ☐ **Cardiomyopathy** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY:

35. ☐ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

36. ☐ **Sepsis**

37. ☐ **Meningitis**

38. ☐ **Pneumonia** (non-PCP)

39. ☐ **Septic Arthritis**

40. ☐ **Endocarditis**

41. ☐ **Sinusitis,** radiographically documented.

NOTE: If you have checked any of the boxes in Section C, proceed to Section E to add any remarks you wish to make about the patient's condition, then proceed to Sections F and G and sign and date the form.

If you have not checked any of the boxes in Section C, please complete Section D. See Part VI of the Instruction Sheet for definitions of the terms used in Section D. Proceed to Section E to add any remarks you wish to make about the patient's condition. Then proceed to Sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. **Repeated Manifestations of HIV Infection,** including diseases mentioned in Section C, items 1–41, but without the specified findings described above, or other diseases, resulting in significant, documented symptoms or signs, (e.g., fatigue, fever, malaise, weight loss, pain, night sweats). **Please specify:**

   a. The manifestations your patient has had;
   b. The number of episodes occurring in the same one-year period; and
   c. The approximate duration of each episode.

   Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same one-year period. (See attached instructions for the definition of "repeated manifestations.")

   If you need more space, please use Section E:

MANIFESTATIONS	NUMBER OF EPISODES IN THE SAME ONE-YEAR PERIOD	DURATION OF EACH EPISODE
"EXAMPLE: Diarrhea"	3	1 month each

AND

2. **Any of the Following:**

   ☐ **Marked restriction of Activities of Daily Living; or**

   ☐ **Marked difficulties in maintaining Social Functioning; or**

   ☐ **Marked difficulties in completing tasks in a timely manner due to deficiencies in Concentration, Persistence, or Pace.**

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.):

F. MEDICAL SOURCE INFORMATION (Please Print or Type):

Name			
Street Address	City	State	ZIP Code
Telephone Number (Include Area Code) ( )		Date	

I declare under penalty of perjury under the laws of the United States of America and the State of California, that the information contained in this medical report is true and correct.

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

➤

FOR OFFICIAL USE ONLY

☐ COUNTY OFFICE DISPOSITION: ☐ DISABILITY EVALUATION DIVISION DISPOSITION:

DHS 7035 A (4/94) Page 3 of 3

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 C
(Medical Report on Child With Allegation of Human Immunodeficiency Virus [HIV] Infection)

A claim has been filed for your patient, identified in Section A of the attached form, for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Services medical release (MC 220) signed by your patient's parent or guardian should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient's parent or guardian.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient's parent or guardian and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- ALWAYS complete Section B.
- Complete Section C, if appropriate. If you check at least one of the items in Section C, go right to Section E.
- ONLY complete Section D if you have NOT checked any item in Section C. See the special information section below which will help you to complete Section D.
- Complete Section E if you wish to provide comments on your patient's condition(s).
- ALWAYS complete Sections F and G. NOTE: This form is not complete until it is signed.

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient's parent or guardian for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected. Complete only the areas of functioning applicable to the child's age group.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to the extent described.
- For children age 3 to attainment of age 18, the child must have a "marked" restriction of functioning in two areas to be eligible for these benefits. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Manifestations of HIV Infection" *(see Item D.1)*:

"Manifestations of HIV Infection" may include any conditions listed in Section C, but without the findings specified there, (e.g., oral candidiasis not meeting the criteria shown in Item 27 of the form, diarrhea not meeting the criteria shown in Item 38 of the form); or any other conditions that is not listed in Section C, (e.g., oral hairy leukoplakia, hepatomegaly).

What We Mean By "Marked" *(see Item D.2.c—Applies Only to Children Age 3 to 18)*:

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or placed in a residential treatment facility.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively in an age-appropriate manner.

DHS 7035 C (Continued) (4/94)

Continued on reverse →

PRIVACY ACT NOTICE

The Department of Health Services (DHS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHS as follows: (1) to enable a third party or agency to assist DHS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 139a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

DHS 7035 C(Cover Sheet) (4/94)

State of California—Health and Welfare Agency | Department of Health Services

MEDICAL REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding the child's treatment for human immunodeficiency virus (HIV) infection.

Applicant's Parent's or Guardian's Signature (Required only if Form MC 220 is NOT attached) ➤	Date

A. IDENTIFYING INFORMATION:

Medical Source's Name	Applicant's Name
Applicant's Social Security Number	Applicant's Date of Birth

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable):

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ In a child less than 13 years of age, **Multiple or Recurrent Pyogenic Bacterial Infection(s)** of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring two or more times in two years
7. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

8. ☐ **Aspergillosis**
9. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs
10. ☐ **Coccidioidomycosis,** at a site other than the lungs or lymph nodes
11. ☐ **Cryptococcosis,** at a site other than the lungs, (e.g., cryptococcal meningitis)
12. ☐ **Histoplasmosis,** at a site other than the lungs or lymph nodes
13. ☐ **Mucormycosis**

PROTOZOAN OR HELMINTHIC INFECTIONS:

14. ☐ **Cryptosporidiosis, Isosporiasis, or Microsporidiosis,** with diarrhea lasting for one month or longer
15. ☐ **Pneumocystis Carinii Pneumonia or Extrapulmonary Pneumocystis Carinii Infection**
16. ☐ **Strongyloidiasis,** extra-intestinal
17. ☐ **Toxoplasmosis,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS:

18. ☐ **Cytomegalovirus Disease,** at a site other than the liver, spleen, or lymph nodes
19. ☐ **Herpes Simplex Virus,** causing mucocutaneous infection, (e.g., oral, genital, perianal) lasting for one month or longer; or infection at a site other than the skin or mucous membranes, (e.g., bronchitis, pneumonia, esophagitis, or encephalitis); or disseminated infection
20. ☐ **Herpes Zoster,** disseminated or with multidermatomal eruptions that are resistant to treatment
21. ☐ **Progressive Multifocal Leukoencephalopathy**

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SECTION C (continued)

22. ☐ **Hepatitis,** resulting in chronic liver disease manifested by appropriate findings, (e.g., intractable ascites, esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS:

23. ☐ **Carcinoma of the Cervix,** invasive, FIGO stage II and beyond

24. ☐ **Kaposi's Sarcoma,** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

25. ☐ **Lymphoma** of any type, (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)

26. ☐ **Squamous Cell Carcinoma of the Anus**

SKIN OR MUCOUS MEMBRANES:

27. ☐ **Conditions of the Skin or Mucous Membranes,** with extensive fungating or ulcerating lesions not responding to treatment, (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES:

28. ☐ **Anemia** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every two months

29. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

30. ☐ **Thrombocytopenia,** with platelet count of 40,000/mm^3 or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or platelet counts repeatedly below 40,000/mm^3 with at least 1 spontaneous hemorrhage, requiring transfusion, in the last 5 months; or with intracranial bleeding in the last 12 months

NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION (E.G., HIV ENCEPHALOPATHY, PERIPHERAL NEUROPATHY) RESULTING IN:

31. ☐ **Loss of Previously Acquired, or Marked Delay in Achieving, Developmental Milestones or Intellectual Ability** (including the sudden acquisition of a new learning disability)

32. ☐ **Impaired Brain Growth** (acquired microcephaly or brain atrophy)

33. ☐ **Progressive Motor Dysfunction** affecting gait and station or fine and gross motor skills

GROWTH DISTURBANCE WITH:

34. ☐ **Involuntary Weight Loss (or Failure to Gain Weight) at an Appropriate Rate for Age) Resulting in a Fall of 15 Percentiles** from established growth curve (on standard growth charts) that persists for 2 months or longer

35. ☐ **Involuntary Weight Loss (or Failure to Gain Weight) at an Appropriate Rate for Age) Resulting in a Fall to Below Third Percentile** from established growth curve (on standard growth charts) that persists for two months or longer

36. ☐ **Involuntary Weight Loss Greater Than Ten Percent of Baseline** that persists for two months or longer

37. ☐ **Growth Impairment,** with fall or greater than 15 percentiles in height which is sustained; or fail to, or persistence of, height below the third percentile

DIARRHEA:

38. ☐ **Diarrhea,** lasting for one month or longer; resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

39. ☐ **Cardiomyopathy** (chronic heart failure; or other severe cardiac abnormality not responsive to treatment)

PULMONARY CONDITIONS:

40. ☐ **Lymphoid Interstitial Pneumonia/Pulmonary Lymphoid Hyperplasia** (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment

NEPHROPATHY:

41. ☐ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

42. ☐ **Sepsis**

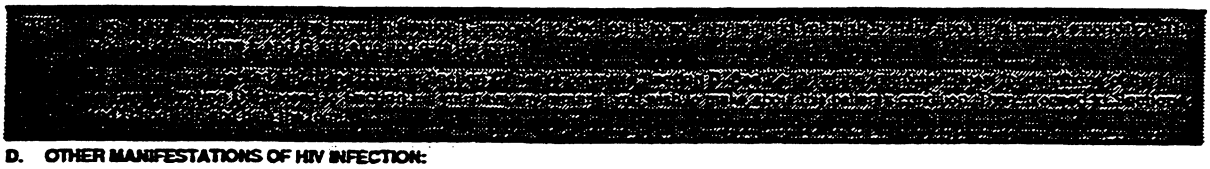
43. ☐ **Meningitis**

44. ☐ **Pneumonia** (non-PCP)

45. ☐ **Septic Arthritis**

46. ☐ **Endocarditis**

47. ☐ **Sinusitis,** radiographically documented



D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. Any Manifestations of HIV Infection Including Any Diseases Listed in Section C, Items 1–47, but without the specified findings described above, or any other manifestations of HIV infection; please specify type of manifestation(s):

_____

_____

_____

AND

2. Any of the Following Functional Limitation(s), Complete Only the Items for the Child's Present Age Group:

a. Birth to Attainment of Age One—Any of the following:

(1) ☐ Cognitive/Communicative Functioning generally acquired by children no more than one-half the child's chronological age, (e.g., in infants birth to six months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing); or

(2) ☐ Motor Development generally acquired by children no more than one-half the child's chronological age; or

(3) ☐ Apathy, Over-Excitability, or Fearfulness, demonstrated by an absent or grossly excessive response to visual stimulation, auditory stimulation, or tactile stimulation; or

(4) ☐ Failure to Sustain Social Interaction on an ongoing, reciprocal basis as evidenced by inability by six months to participate in vocal, visual, and motoric exchanges (including facial expressions); or failure by age nine months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age; or

(5) ☐ Attainment of Development or Function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social).

b. Age One to Attainment of Age Three—Any of the following:

(1) ☐ Gross or Fine Motor Development at a level generally acquired by children no more than one-half the child's chronological age; or

(2) ☐ Cognitive/Communicative Function at a level generally acquired by children no more than one-half the child's chronological age; or

(3) ☐ Social Function at a level generally acquired by children no more than one-half the child's chronological age; or

(4) ☐ Attainment of Development or Function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by 1, 2, or 3.

c. Age 3 to Attainment of Age 18—Limitation in at least 2 of the following areas:

(1) ☐ Marked impairment in age-appropriate Cognitive/Communicative Function (considering historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

(2) ☐ Marked impairment in age-appropriate Social Functioning (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

(3) ☐ Marked impairment in Personal/Behavioral Function as evidenced by marked restriction of age-appropriate activities of daily living (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

(4) ☐ Deficiencies of Concentration, Persistence, or Pace resulting in frequent failure to complete tasks in a timely manner.

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.):

F. MEDICAL SOURCE INFORMATION (Please Print or Type):

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code)	Date
( )	

[redacted]

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

➤

[redacted]

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

WORKER OBSERVATIONS - DISABILITY

Applicant _____ SSN _____

Check appropriate responses and explain in Remarks where necessary.

1. Did this person appear Pale? _____ Jaundiced (yellow)? _____
2. Was this person wearing a hearing aid? Yes ☐ No ☐
3. Was this person wearing glasses? Yes ☐ No ☐
   a. During the interview, did this person use a magnifying glass? Yes ☐ No ☐
4. Did this person
   a. Use a cane? Yes ☐ No ☐
   b. Use a wheelchair? Yes ☐ No ☐
   c. Use a walker? Yes ☐ No ☐
   d. Walk with a limp? Yes ☐ No ☐
   If Yes, Right_____ Left_____
5. Did this person
   a. Appear to have an injury? Yes ☐ No ☐
   If Yes, explain below.
   b. Appear to be confused/disoriented? Yes ☐ No ☐
   If Yes, explain below.
   c. Have a noticeable breathing difficulty? Yes ☐ No ☐

Remarks: _____

EW: _____ Date: _____

DHS 7045 (8/93)

22 C-5 – PROVIDING CWD WORKER OBSERVATIONS

Because Eligibility Workers (EWs) have direct contact with clients, observations about a client's condition should be provided to SP-DED. Observations can assist SP-DED by identifying additional conditions or by enhancing information provided by client.

1. USE OF MC 221 OR DHS 7045

EWs may record observations about medical conditions in "CWD Representative Comments" section of MC 221 or on the optional DHS 7045 (Worker Observations - Disability) form. The DHS 7045 may be submitted to SP-DED with disability packet, should observations be extensive and exceed space provided on MC 221, or at a later date, should EW have additional observations to provide.

Unusual behaviors which suggest mental conditions should be noted, as they are frequently not admitted to by client and because they may severely restrict client's ability to work.

EW comments will not be used exclusively to determine if client is or is not disabled.

2. USE OF WORKER OBSERVATIONS BY SP-DED

As SP-DED performs a complete evaluation of a claim, and not only client's alleged condition, it is very important that all conditions be identified.

Example: Client alleged disability on the basis of stomach cancer but did not say she had back and foot problems. She thought the cancer was the disabling problem because it was the only condition being treated. SP-DED determined that the cancer was not disabling. Because the EW noted on the DHS 7045 that client was limping and appeared uncomfortable sitting, SP-DED also explored these observations and found client had back and foot problems. Client was found disabled based on her back and foot problems.

3. GUIDELINES

The following guidelines will assist EWs in providing observations to SP-DED and include some of the more frequently occurring actions or behaviors which may be observed. They are not all-inclusive.

Physical Mobility	Difficulty walking, standing, sitting, or need for another person's assistance in doing these;
	Use of mobility devices, such as wheelchairs, braces, canes, crutches;
	Discomfort while sitting for extended periods of time, or the need to stand periodically to stretch or relax certain muscles;

Difficulty with joints or fingers with stiffness, swelling, shaking, trembling, or the inability to flex fingers resulting in difficulty writing, picking up forms, etc.

Example: Client stood up periodically throughout the interview. She said that she had an inflamed disc in her back that made it hard for her to sit for long periods for time.

Physical Appearance

Height and weight, recent, significant change in weight, unusually thin, overweight, short, malnourished appearance;

Unusual skin conditions such as scaling, peeling, unusual color, scarring, with signs of disfigurement or deformity;

Absence of any extremities, and use of a prosthetic device.

Example: Client had noticeable difficulty walking and sitting. He wore a brace on the right leg and walked with a limp. He braced himself as he sat down. However, he had full use of his upper extremities.

Other Physical Problems

Breathing difficulties, such as frequent coughing or rapid breathing;

Example: Client frequently coughed throughout the interview. When asked if she had a cold, she said, "No, I just cough a lot in the morning".

The appearance that drugs, alcohol, or medication may be affecting client's physical/mental functioning.

Special Senses

Problems with hearing, use of hearing aid, reliance on another to explain what is said, hears only very loud speech;

Problems with seeing, use of glasses, use of magnifying glass to read forms;

Problems with speaking, speech is difficult to understand, slurred or impeded.

Example: Client indicates difficulty reading and hearing. She used a magnifying glass when reading with her glasses on. She said she had an amplifier on her phone, but she was noted not to wear a hearing aid and was able to answer questions without trouble.

Mental And Emotional Status

Does not know his/her name, date and/or time, is disoriented, does not know where he/she is or the reason for the interview;

Has difficulty understanding things, not due to a language barrier, limited attention span and poor memory;

Conversation is repetitive or wandering and responses to questions are inappropriate;

Exhibits signs of deterioration of personal habits, such as poor hygiene or grooming;

Shows signs of emotional distress, such as unusual crying or laughter, or inappropriate outbursts of anger;

Has unusual mannerisms, such as constant twitching of the neck, and inappropriate dress;

Example: Client arrived for appointment at correct time but wrong day. She rambled on about various subjects. She seemed confused and disoriented and her memory was poor. She was vague and evasive when discussing problems.

22C-6 – ASSEMBLING AND SENDING SP-DAPD PACKETS

Disability packets containing forms filled out by client or CWD will initiate a disability referral. SP-DAPD uses these forms and other information in its disability evaluation process.

1. PREPARING THE PACKET

A. LIMITED REFERRAL

A limited referral packet contains The following forms:

MC 221 — Disability Determination and Transmittal, and the reason for limited referral shown in "Remarks" section.

1. Copy of prior MC 221, if available.

Submit Only Under These Circumstances:

1. When packet is sent within 30 days of SP-DAPD's decision for a reevaluation and no new treating sources are alleged.

2. When an earlier onset date on an approved case is needed, if within 12 months of application, and no new treating sources are alleged for earlier onset date.

   NOTE: If SP-DAPD is unable to establish an earlier onset date with information available, it may return the case as a Z56 to request additional information.

3. When client is discontinued from Title XVI due to income or resources and not in receipt of Title ll benefits. CWD must make a diligent search with SSA, MEDS or IEVS to verify reason client was discontinued from SSI, which could eliminate the need for a Limited Packet being sent to SP-DAPD for verification. This includes those who were entitled to IHSS prior to being discontinued from SSI due to earnings.

   NOTE: Before sending packet to SP-DAPD to verify SSI status, CWD must annotate on the MC 221 why the information was unobtainable. Packets without this information will be returned as a Z56 to CWD.

4. When application is made on behalf of a deceased client and a retroactive onset date is not requested and appropriate documentation of death is sent.

NOTE: When a retroactive onset date of disability is requested, counties must submit a full-disability packet to SP-DAPD because the requested onset date of disability cannot be established based on the death certificate. In this instance, follow MEPM procedures (22C-6.2) for submitting a full-disability packet.

NOTE: If death certificate is not available, MC 220 signed by appropriate next-of-kin should be sent.

5. When after a diligent search attempt with SSA, MEDS or IEVS to obtain SSI case status, and the CWD still is unable to verify receipt of SSI benefits, CWD may request only verification of SSI benefits for IHSS purposes from SP-DAPD.

NOTE: Before sending packet to SP-DAPD, CWD must annotate on the MC 221 why information was unobtainable. Packets without this information will be returned as a Z56 to CWD.

B. FULL REFERRAL

A full referral packet contains The following forms:

MC 179	90 Day Status Letter 1. For applicant: sent at 80 days after application date (SAWS 1), if packet has not yet been sent to SP-DAPD for any reason. 2. For beneficiary: sent at 80 days from date MC 223 was signed. (MC 179 box on MC 221 must be checked, if applicable.)
MC 220	Authorization for Release of Medical information for each treating source (plus three extra releases with signatures and date.)
MC 221	Disability Determination and Transmittal
MC 223	Applicant's Supplemental Statement of Facts for Medi-Cal based on disability.
Appointment of Representative, *if Applicable*	Allows SP-DAPD to discuss specific case issues with Authorized Representative.

Other

Any applicable medical documentation previously received, including documentation used for granting PD. If medical records are readily available, they may be submitted with packet. However, do not delay sending packet to obtain medical records.

Please see **Guidelines to Requesting Medical Records"** (on pages 6.7-12) for further information regarding the necessary medical evidence for each specific impairment. Also, (on page 6.13) see **"DED Packet Review Checklist"** for a quick reference guide before sending a full packet to State Programs DED.

C. PACKET INFORMATION FOR RETROACTIVE MEDI-CAL

At Initial Application

1. Determine if client requested retroactive Medi-Cal on MC 210;
2. Have client complete MC 210A for specified months; and,
3. Assemble and send **full** packet to SP-DED.

Within 12 Months Of Original Application And Prior To SP-DED Decision

1. Have client complete MC 210A and specify months requested;
2. Complete and send MC 222 to SP-DED and specify retro months requested under "Other" section.

Within 12 Months Of Application And After A Favorable SP-DED Decision

1. Have client complete MC 210A and specify months requested;
2. Complete and send **limited** packet to SP-DED and indicate retro onset on MC 221, along with copy of MC 221 which showed the SP-DED allowance.

D. REFERRALS FOR DISABLED FORMER SSI/SSP RECIPIENTS

Clients under 65 years of age who are discontinued from SSI/SSP for reasons other than cessation of disability (e.g., excess income and resources), and who are not receiving Title II benefits, will need to be referred to SP-DED to determine if disability established by SSA still exists. Disabled former SSI/SSP recipients may also include individuals in long term care (LTC).

These clients fall under Ramos v. Myers court settlement, which entitles client to an extension of Medi-Cal after SSI discontinuance, pending CWD determination of eligibility based on current information from client. Additional information on Ramos v. Myers can be found in Article 5E.

Responsibilities

CWD

1. Submit a limited packet to SP-DED immediately upon client's application for Medi-Cal. Only the MC 221 is needed. Indicate in the Comments Section that "SSI/SSP discontinued for reasons other than cessation of disability".

2. Grant temporary Medi-Cal eligibility pending a formal disability determination by SP-DED.

SP-DED

1. SP-DED may be able to adopt SSA's disability decision and onset date by querying SSA records. The MC 221 will be sent to CWD indicating approval.

2. If SSA's mandatory reexam date (SSA expected the medical condition to improve) has passed or if SSA's disability decision cannot be verified, SP-DED may return a limited packet to CWD as a Z56 case (no determination). A full packet will be requested.

E. THE RAILROAD RETIREMENT BOARD (RRB) PACKET REFERRAL

The RRB, a federal agency responsible for the retirement system for railroad employees, uses SSA's disability criteria for Total and Permanent Disability benefits, but not for its Occupational Disability benefits.

Recipients of Occupational Disability who apply for Medi-Cal disability must have their claim sent to SP-DED for a disability evaluation.

The following steps are taken when an applicant for Medi-Cal based on disability, or when a Medi-Cal beneficiary requests reclassification as a Medi-Cal disabled person:

1. Award Letter Available

When a client presents an RRB disability benefit award letter, benefit change notice, or other verification from RRB, determine what type of RRB disability benefit is awarded.

Total And Permanent Disability

Client is disabled for Medi-Cal purposes. Retain copy of RRB's written statement; OR, document disability onset date (or date benefits began), type of RRB disability award, and date of verification for the file.

Occupational Disability

Occupational Disability is based on an inability to perform one's last railroad job and does not consider the ability to perform other work. Submit a **full** packet (MC 220, MC 221, MC 223) to SP-DED.

Type Of Award Not Identified

Client is responsible for obtaining a written statement from RRB which identifies the type of disability benefits awarded. Set a reasonable time frame for compliance. If the client is unable to obtain this verification, submit a full packet to SP-DED and an MC 220 which authorizes SP-DED to obtain copies of the RRB award information.

2. Award Letter Not Available

Occupational Disability

If client states that award is for Occupational Disability, and does not wish to obtain verification from RRB, refer **full** packet to SP-DED and include MC 220 which authorizes SP-DED to obtain copies of RRB award information.

Reclassification Request

If Medi-Cal beneficiary alleges that RRB has determined that he/she is disabled and would like to be reclassified to Medi-Cal disabled category but fails, or refuses without good cause, to cooperate in providing proof about RRB disability benefits, deny Medi-Cal request for reclassification on basis of failure to cooperate.

DO NOT DISCONTINUE MEDI-CAL BENEFITS until/unless all other linkage ceases or another reason for discontinuance exists.

2. SENDING THE PACKET

Check forms and information included in packet to ensure consistency of client's name, Social Security number and date of birth. Resolve any discrepancy pertaining to disability issues before sending packet.

Send packet to SP-DED no later than ten calendar days after date on the Statement of Facts (MC 223) is signed by client, unless there are circumstances beyond CWD's control. When the ten day rule is not met, the situation must be documented in case. However, do not hold packet pending CWD's evaluation/verification of other non-disability factors. If packet has already been sent and it is discovered that client is ineligible, send MC 222 to SP-DED.

Example: Client fails to give completed information to CWD timely. Case record documents this as the reason for not sending packet within ten days. CWD sends completed disability packet to SP-DED while continuing to verify property issues. While packet is at SP-DED, CWD discovers that client is ineligible. CWD sends MC 222 informing SP-DED that client is ineligible so that the disability evaluation can be stopped.

GUIDELINES TO REQUESTING MEDICAL RECORDS

This is a guide to assist counties who wish to expedite a client's case by obtaining or requesting medical evidence specific to the client's impairments. The information is required for evaluation of Medi-Cal disability cases and helps to avoid the need for a consultative examination.

NOTE: UNDER NO CIRCUMSTANCES ARE THE COUNTIES TO DELAY SENDING DISABILITY PACKETS TO SP-DED PENDING RECEIPT OF MEDICAL RECORDS OR DENY THE APPLICATION FOR FAILURE TO PROVIDE THE RECORDS.

Requirements by Body System

MUSCULOSKELETAL SYSTEM - Fractures, Back, Arthritis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Surgical Reports
- X-Ray Reports - If serial x-rays are available, only the earliest and latest results are needed
- Laboratory Reports - in cases involving inflammatory or rheumatoid arthritis
- Medical and surgical notes describing pain, range of motion, atrophy, sensory motor, reflex changes, gait disturbances, and functional restrictions

SPECIAL SENSE ORGANS - Vision, Hearing & Speech

- Admission Summaries
- Discharge Summaries, if available, History/Physical Examinations
- Surgical Reports
- Sight: Central visual acuity before and after best correction; and visual field charts
- Hearing: Audiograms - aided/unaided; speech discrimination tests; and electronystagmography (ENG)

Because of the special provisions for the disabled blind claimant, the record of the earliest date the individual became statutorily blind is essential - i.e. the first date visual acuity in the better eye with correction was only 20/200 or less.

RESPIRATORY SYSTEM - Bronchitis, Emphysema, COPD, Asthma, TB

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Restrictive and Obstructive Disorders
  Chest x-ray reports - Upright films are preferable. If serial x-rays are available, only the earliest and latest results are needed.
- Bronchograms
- PFT - with spirograph (tracings) before and after bronchodilators
- Blood gas studies and/or diffusion studies at rest and at exercise
- Culture Reports - if any are available

CARDIOVASCULAR SYSTEM - Heart Disease

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- EKG tracings (especially if documentation of M.I.) with interpretation and tracings
- Reports of serial enzymes
- Exercise (Treadmill) EKG (TET) with Tracings
- Thallium Scans
- Angiogram
- Coronary catheterization
- Echocardiogram
- CBC
- Chest X-Ray
- Description of Chest Pain

PERIPHERAL VASCULAR DISEASE

- Same information as listed above for Cardiovascular System
- Oscillometry - Doppler with exercise if available
- Arteriography
- Laboratory Reports (earliest and latest results are needed)
- If serial x-rays, only the earliest and latest results are needed.

DIGESTIVE SYSTEM - Liver, Ulcers, Colitis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Surgical Reports

- Height and Weight
- X-Ray Reports - If serial x-rays are available, only earliest and latest results are needed.
- Laboratory Reports (serial liver function tests over 5+ months)
- Malabsorption stool tests
- Reports on any endoscopic procedures

GENITOURINARY SYSTEM - Kidney Failure

- Hemodialysis - any records, whether undertaken or planned
- Any indication whether dialysis is chronic or acute
- Any indication of the need for a kidney transplant
- Serum creatinine or creatine clearance tests
- Renal Biopsy Reports
- Sonograms
- Renal Profusion Studies
- CBC
- Weight & Height
- IV Pyelogram
- Cystoscopic examination
- X-Ray Reports - If serial x-rays are available, only the earliest and latest results are needed.

HEMIC AND LYMPHATIC SYSTEM - Anemia, Sickle Cell, Leukemia

- All Laboratory Work - especially serial hematocrit
- Sickle Cell Anemia - any documentation of thrombotic crisis hemorrhage or blood clots.
- X-Ray reports
- Any Pathology Reports

SKIN

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Dermatological Report
- Progress Notes
- Biopsy Reports

ENDOCRINE AND OBESITY SYSTEMS

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Laboratory Studies
- X-Rays for Osteoporosis and Osteoarthritis
- Neurological Examination
- Ophthalmological Examination
- Surgical Reports
- Doppler Tests
- Arteriogram
- Height and Weight
- Description of Limitation of Motion or Functional Limitation
- Chest X-Rays
- PFT with Tracings

NERVOUS SYSTEM

Common Conditions: Epilepsy, CVA, Brain Tumors, Cerebral Palsy, Parkinson's Disease, Multiple Sclerosis, Polio, Spinal Cord Injury

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Neurological Examinations
- EEG
- Anti-convulsant blood levels
- CT Scans and X-Rays
- Psychological Examinations
- Surgical Reports
- Muscle biopsy
- EMG
- Nerve conduction test

MENTAL DISORDERS

- Psychiatric Evaluation
- Psychological test results
- Psychological evaluations

- All records (including Admission and Discharge Summaries) of all hospitalizations or treatments during the past (four) 4 years.
- Description of daily activities and function levels
- List of all prescribed medication
- History of drug, alcohol use or dependence

NEOPLASTIC DISEASES - Cancer

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Biopsy and surgical pathological reports
- Surgical Reports
- CAT Scans, MRI
- Chemotherapy, radiation effects
- Laboratory Reports
- Tumor Board Recommendations

IMMUNE SYSTEM - HIV Infection, AIDS, Systemic Lupus, Scleroderma, Connective Tissue Disorder, Vasculitis, Polymyositis

- Admission Summaries
- Discharge Summaries, if available
- History/Physical Examinations
- Laboratory Reports (blood tests, stool tests)
- Biopsy Reports
- Microscopy (histology, cytology, pathology)
- IV test (antibody, antigen, cultures)
- Other Cultures (sputum tests)
- PFTs
- Blood Gas Studies
- Neurological Exams
- Angiography
- Clinical findings cognitive/motor dysfunction
- Weight loss with diarrhea/weakness/fever - (Height and Weight)
- Brain imaging
- Description of how fatigue impacts activities of daily living
- Psychological Evaluations and Test Results
- History of drug and alcohol abuse

DED PACKET REVIEW CHECKLIST

The use of this checklist will help to reduce disability packet returns from DED by ensuring that all forms are present and correctly completed.

A. MC 221 (6/93 revision) See the Medi-Cal Eligibility Procedures Manual Section 22 4.5/7

( ) Is the CWD address on all three copies of the MC 221?
( ) Does item #5 include the month/day/year, and Retro Onset, if needed?
( ) If the case is a resubmitted packet, has a new MC 221 been prepared; is a copy of the prior MC 221 attached?
( ) If a reevaluation is being requested, has the reason for reevaluation been stated in Item #10?
( ) If a reopening is being requested because of a hearing remand, is a copy of ALJ's decision attached? (copy of the entire decision - not just the last page of the decision).
( ) For redetermination cases, is it specified, in Item #10, whether the break in aid was due to a medical or a non- medical reason; is a copy of the prior MC 221 attached?
( ) If there are any unavoidable omissions in the packet (e.g., missing address information for a out of state medical source which the applicant cannot provide) has an explanation as to why the information cannot be provided been stated in Item #10

B. MC 223 (6/94 revision) See the Medi-Cal Eligibility Procedures Manual Section 22 C-4.7/11

( ) Has the MC 223 been thoroughly completed?
( ) Is Item #6 filled in with the applicant's alleged medical problem(s)? (Do not write "see attached"or "see medical records", etc.)
( ) Are complete addresses and dates of treatment (at least month/year) given for each source listed in Items #7-10 and on Page 8?

C. MC 220 (7/93 revision) See the Medi-Cal Eligibility Procedures Manual Section 22 C-4.2/5

( ) Is there a sufficient number of MC 220s in the packet to cover every source listed on the MC 223-Items #7-10 and on Page 8?
( ) Are there three additional blank MC 220s, signed by the applicant, included?
( ) Are all MC 220s signed by the applicant? If not, **indicate** specific physical or mental incapacity that prevents applicant from signing **and** specify the relationship of person signing for the applicant on the release. The **"I authorize..."** line is for the medical source's name **only**.
( ) If applicant is deceased, send death certificate and/or hospital admission notes with **reason for death and the doctor's signature**; otherwise send a **complete** packet.
( ) Please make sure that the MC 220s have not been altered.
( ) Are the MC 220s signed with an **X** or an unrecognizable symbol? If so, the MC 220s must also be signed by a witness **and** the relationship of the witness to the applicant must be stated on the release.
( ) Do not date the MC 220s. (MC 220s that are 90 days after the date of application cannot be used).

22C-7 – COMMUNICATING WITH STATE PROGRAMS – DISABILITY AND ADULT PROGRAM DIVISION (SP-DAPD FORMERLY SP-DED) AND DHS ABOUT CHANGES AND STATUS

1. NOTIFYING SP-DAPD ABOUT CHANGES

A. MC 222 LA/MC 222 OAK – DAPD PENDING INFORMATION UPDATE FORM

When a disability evaluation is pending, CWD will notify SP-DAPA about changes in client's situation, which affect eligibility or which would enable SP-DAPA to contact client. MC 222 LA/Oak is used to submit changes and to report information to SP-DAPA

CWDs who send plackets to Los Angeles SP-DAPA will use MC 222 LA. Other CWDs who send packets to Oakland SP-DAPA will use MC 222 Oak.

B. TYPE OF CHANGES TO REPORT TO SP-DAPD

1. Change in client's address.
2. Changes in client's name, telephone or message number.
3. Denial or discontinuance of client on basis of nonmedical information (e.g., excess property).
4. Withdrawal of application.
5. Cancellation of Authorization for Release of Information (MC 220) by client.
6. Death of client.
7. Receipt of new medical evidence (attach new medical evidence to MC 222).
8. Availability of interpreter (Provide name and phone number).
9. Change in EW.
10. Any other pertinent information, which affects SP-DAPD's actions on a pending case.

C. SP-DAPD ADDRESSES

Disability packets from **Imperial, Los Angeles, Orange, Kern and San Diego Counties** must be Send to:	California Department of Social Services Disability and Adult Programs Division **Los Angeles State Programs Branch** P.O. Box 30541, Terminal Annex Los Angeles, CA 90030 **(213) 480-6400/ 8-677-6400 CALNET** **FAX**: (800) 869-0188
Disability packets from **all other Counties** must be sent to:	California Department of Social Services Disability and Adult Programs Division **Oakland State Programs Branch** P.O. Box 23645 Oakland, CA 94623-0645 **(510) 622-3756/ 8-561-3756 CALNET** **FAX:** (800) 869-0203

D. MC 4033 – DISABILITY LISTING UPDATE FORM

CWDs will use MC 4033 to notify the state of any changes to 1) Medi-Cal Liaison List for Disability Issues, or 2) Medi-Cal Liaison List for Quarterly Status Listings for Pending and Closed Disability cases. Check appropriate list and specify items being updated.

These lists are updated on a regular basis and contain names and phone numbers of CWD liaisons, which DHS-MEB and SP-DAPD may need to communicate with CWDS.

2. RECEIVING AND REQUESTING CASE STATUS INFORMATION FROM SP-DAPD

A. QUARTERLY COMPUTER STATUS LIST

CWDs will receive a quarterly computer status list from SP-DAPD regarding pending and closed disability cases, along with instructions on its use. If a particular case was forwarded to SP-DAPD prior to most recent quarterly list and does not appear on list, CWD may contact SP-DAPD Program Support unit by telephone or in writing to obtain status information, as follows:

Los Angeles State Programs Branch

Myra Ancla
Operations Support Analyst
CDSS-DAPD-LASPB
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 480-6453

Oakland State Programs Branch

Lis Okamura
Operations Support Analyst
CDSS-DAPD-OSPB
P.O. Box 23645
Oakland, CA 94623-0645
(510) 622-3787/ 8-561-7387 CALNET

B. USE OF DISANBILITY LISTING UPDATE FORM (MC 4033)

A combined list of Medi-Cal liaisons, district office codes, addresses and telephone numbers will be used to distribute the quarterly status reports. Form MC 4033 (Disability Listings Update) should be used and sent to the department of Health Services (DHS) to provide updated information to the list. DHS's address is listed on the form.

C. QUESTIONS AND INQUIRIES ON SPECIFIC CASES

In urgent or unusual circumstances, questions and inquiries about specific cases may be directed to the Disability Evaluation analyst (DEA) assigned to the case, or the Unit Manager. To determine which DEA or Unit is assigned to case, provide client's name and Social Security number to Masterfiles, at the following numbers:

Los Angeles State Programs Branch

Masterfiles:
(213) 480-6400
8-677-6400 CALNET

Oakland State Programs Branch

Masterfiles:
(510) 622-3756
8-5613756 CALNET

3. CONTACTING THE STATE DEPARTMENT OF HEALTH SERVICES (DHS)

A. PROBLEMS WITH CASE STATUS INFORMATION

If CWDs experience problems with obtaining case status information which cannot be resolved with SP-DAPD, appropriate CWD staff should notify the state Department of Health Services, Medi-Cal Eligibility Branch (DHS-MEB).

B. PROBLEMS WITH DISABILITY REFERRAL POLICIES AND PROCEDURES

CWDs should refer disability referral policy and procedure issues to DHS-MEB through their Medi-Cal liaison or disability coordinator.

C. CONSISTENTLY DELAYED DECISIONS

Where disability decisions are consistently delayed (i.e., not completed in a timely manner), CWD should notify DHS-MEB through appropriate channels.

D. UPDATING THE MEPM DISABILITY PROCEDURES

DHS-MEB may be informed in writing about corrections, updates or additions to the MEPM so that disability procedures may be kept up to date.

22 C-8 -- PROCESSING SP-DAPD Decisions

1. DISABLED

A. SP-DAPD ACTION

Fully Favorable Allowances — MC 221 disability portion will be completed and returned to counties.

Partially Favorable Allowances — MC 221R Attachment will be included with MC 221 decision document if disability onset date is **AFTER** date of application, or if client was not found disabled during requested period of retroactive coverage.

A "Rationale" for decision will give the reasons for the less than favorable allowance.

ALLOWANCE CODES

MIDAS	DEFINITION
A61	Condition meets severity of SSA Listing of Impairments.
A62	Condition equals severity of Listing. For adults.
A63	Medical/vocational considerations result in favorable decision for adults.
A64	Medical/vocational considerations -- arduous unskilled work profile.
A55	Continuance for reexamination case review.
A98	Reversal by Administrative Law Judge at State Hearing.
A99	Adoption of federal (SSA) Allowance/Continuance decision
B61	Statutory blindness.
A65	Disabled child claim - medically equals severity of Listing.
A66	Disabled child claim - functionally equals severity of Listing.

B. CWD ACTION

Approve — Applicant is disabled, if otherwise eligible, or reclassify beneficiary as Disabled-MN.

Tickle — Case for re-submittal to SP-DAPD as a re-exam case when a re-exam date is shown. Re-exam dates are set when medical improvement is expected. DHS will send a reminder letter to counties in the month the re-exam case is due

Mail	Rationale for decision to client, which explains a partially favorable allowance. **NOTE**: The MC 221 and MC 221(R) Attachment are **NEVER** sent to client.

2. NOT DISABLED

A. SP-DAPD ACTION

MC 221R	Block is checked "is not disabled" or "is not blind", is **NEVER SENT TO CLIENT** for any reason. The top of the document is annotated "Do Not Mail to Applicant."
MC 221 (R) Attachment (decision	Explains specific reasons for denial and is **NEVER SENT TO CLIENT** for any reason. The top of the document is annotated "Do Not Mail to Applicant."
Also attached to the MC221R will be the Rationale	The Rationale is an unnumbered, untitled, and unsigned letter, which explains the reason for denial, and "**Must be mailed to client**". The language at the top of the letter will inform CWD to "Mail to Applicant."

DENIAL CODES

MIDAS	DEFINITION
N30/N41*	Condition not severe.
N31/N42*	Capacity for SGA -- any past relevant work.
N32/N43*	Capacity for SGA -- other than past relevant work.
N34/N45*	Condition prevented SGA for a period of less than 12 months. (For child, condition disabling for a period of less than 12 months.)
N35/N46*	Condition prevented SGA at time of decision but is not expected to prevent SGA for a period of 12 months. (For child, condition disabling at time of decision but not expected to be disabling for a period of 12 months.)
N43/N51*	Disabled child claim impairment severe - but does not meet or medically/functionally equal.
N44	For child, impairment not severe. With or without visual impairment alleged.
N41	Blind evaluation only -- not statutorily blind.
N57	250% Working Disabled Program- Vocational Denial
Z53	Adoption of federal (SSA) denial/cessation decision - SSA's disability decision is controlling over Medi-Cal's decision.
N55	Cessation on re-examination case review.
Z59	Adoption of Federal Denial Cessation Decision where DA/A was material to the decision.

* Indicates visual impairment alleged.

B. CWD ACTION

Evaluate	Evaluate eligibility under other existing Medi-Cal *linkage before denying/discontinuing client.*
Deny/Discontinue Claim	If disability is the only linkage to Medi-Cal, client will be denied/discontinued.
Send Notice of Action (NOA)	If denied/discontinued, attach Rational to NOA; if it is not attached, the NOA will be invalid.

3. NO DETERMINATION DECISIONS

"Z" codes indicate that no substantive decision was made to allow or deny a claim, and generally signify that some action is needed by CWD. After taking appropriate action, CWD must send a *90-Day Status Letter (MC 179)* to client (except for Z56 and Z55 cases), if it is now the 80th day, or if it is evident that SP-DAPD will not be able to make a decision by the 90th day. If MC 179 is sent to client, include copy in packet being resent to SP-DAPD.

NO DETERMINATION CODES

MIDAS	DEFINITION
Z56	Withdrawal by CWD. (When CWD requests that SP-DAPD stop development due to withdrawal of claim, SP-DAPD will do so and send MC 221 to CWD. (After sending NOA, no further CWD action is necessary.)
Z55	CWD return for packet deficiency includes failure issues. This return from SP-DAPD means that additional information is needed. CWD will complete the information requested and forward packet to SP-DAPD
Z70	Duplicate cases – prior case in same State Programs Branch.
Z71	Duplicate cases – prior case in other State Programs Branch.
Z56	Other no determination situations, includes failure issues (non-redetermination cases).
Z56	Other no determination situations In redetermination cases only.
Z56	Other no determination situations for redetermination cases with inappropriate re-exam dates.

A. SP-DAPD ACTION IN Z56 DECISIONS

MC 221 Returned to CWD

SP-DAPD will indicate that a decision could not be made and why.

SP-DAPD may ask help in locating client, obtaining client's cooperation in attending a consultative exam, completing forms, or having client contact SP-DAPD.

B. CWD ACTION FOR Z56 DECISIONS

1. Evaluate If Good Cause Exists

CWD will attempt two separate contacts with client (phone, letter or in person), per Title 22, Section 50175 (a) (1) and (6), to obtain client cooperation or needed information. If good cause is claimed, determine if there is good cause for non-cooperation. Good cause includes:

a. Failure of CWD to provide client with appropriate forms.

b. Failure of CWD to inform client that failure to cooperate with SP-DAPD will result in denial/termination.

c. Failure of postal service to deliver required form(s) or information in a timely manner.

d. Physical or mental illness or incapacity of client or authorized representative which precludes timely completion of requested information or requests to be present at scheduled appointments.

e. Level of literacy along with social or language barriers which precludes client or authorized representative from comprehending instructions.

f. Failure of CWD to properly process SP-DAPD packet.

g. Unavailability of transportation to reach a required destination.

If Good Cause Exists

After obtaining client's cooperation, CWD must resubmit packet:

1. If DAPD returned the packet within 30 days of being resubmitted, CWD will send a limited packet containing a new MC 221 if there are no new allegations or treatment sources; **or**

2. If it has been more than 30 days since DAPD returned the packet, CWD must send a full packet containing a new MC 221 and if new medical conditions are

claimed, and/or there are new or additional medical sources or information, a new MC 223 will be needed,

and

3. Additional MC 220s, as necessary.

If Good Cause Does Not Exist — CWD will deny application or discontinue beneficiary, if no other linkage exists.

2. Determine Whether State Hearing Was Requested

If State Hearing Requested by Client — CWD shall follow the decision of the hearing.

If State Hearing Not Requested by Client — CWD must have the client reapply.

22 C-9—PROCESSING REEXAMINATIONS, REDETERMINATIONS AND REEVALUATIONS

I. BACKGROUND

Cases which have had a decision made by State Programs-Disability and Adult Programs Division (SP-DAPD) formerly known as SP-DED, shall be resubmitted for another review by SP-DAPD for any of the following reasons:

A. Reexaminations
B. Redeterminations
C. Reevaluations

IMPORTANT: Because the criteria for resubmitted cases differ from initial referrals, the type of referral must be correctly identified on the MC 221. Include a copy of prior MC 221 in SP-DAPD packet whenever possible to provide a more complete picture of client's overall medical condition. If the copy of the prior MC 221 is not obtainable, note this on the new MC 221.

II. PROCEDURES

A chart at the end of this section summarizes the procedures and identifies the types of resubmitted cases, criteria for resubmitting cases, the forms to include in the disability packet, and the client's eligibility status while a SP-DAPD decision is pending.

A. REEXAMINATIONS

Most reexaminations (reexams) are mandatory reexams because medical improvement is expected. The reexam date is shown on the prior MC 221. In most cases, the beneficiary will continue to be considered disabled until his/her medical condition has improved and has been determined no longer disabled. Medical reexams are needed when one of the following occurs.

1. **No Federal Disability Decision Involved**

a. SP-DAPD will notify Department of Health Services (DHS) of the cases currently due for medical reexam. DHS will purge the list (i.e., deleting beneficiaries that have Social Security disability entitlement) and forward the list to the Medi-Cal disability liaison in each affected county. Upon receipt, counties should submit a full-disability packet to SP-DAPD within 90 days from the list date or notify DHS by returning the list indicating the reason why the disability packet was not sent.

b. The EW observes or receives information that the client's medical condition may have improved.

Examples:

Client becomes employed within 12 months of the date of application for disability.

Client came into the office using a walker or crutches, but is observed leaving the office without their use.

c. During a case review, the EW notices that the medical reexam date is past due.

The County Welfare Department (CWD) will submit a full disability packet to SP-DAPD for each reexam case. A full packet consists of a current MC 221, a copy of the prior MC 221, an MC 223 and a signed and dated MC 220 for each medical source listed on the MC 223. Also include three additional signed and dated MC 220's in case additional sources are identified. Any new medical records or reports should also be included.

EXCEPTION: If the client's file shows that the Social Security Administration (SSA) determined the client to be disabled and SP-DAPD adopted SSA's decision, contact SSA immediately to determine whether disability continues. If SSA benefits continue, no referral to SP-DAPD will be needed when the reexam date is due, because SSA's determinations are binding until SSA revises its decision.

If SP-DAPD adopted an SSA allowance and SSA finds that the beneficiary is no longer disabled, follow procedures similar to those under, "Federal Disability Decision Involved." Medi-Cal benefits cannot be discontinued until the SSA decision has become "final," meaning that the beneficiary no longer has an appeal pending at SSA on the cessation issue. In this instance, CWDs will need to periodically check (e.g., at each annual redetermination) with the beneficiary or with SSA to obtain status of the SSA appeal. CWDs can also look on the MEDS INQP screen in the "Appeal And Notice Of Action Information" field under "Appeal-Level" to check the status of an SSA appeal; however, this information is not always updated.

2. **Federal Disability Decision Involved**

a. When SP-DAPD initially allows disability and a reexam is due and if a subsequent SSA federal disability claim is allowed, SP-DAPD will adopt the federal medical reexam date if case is not pending or if the reexam is set at a future date.

i. If SP-DAPD received a referral from the CWD on a case where a federal SSA Title II/SSI disability medical reexam case is not pending, SP-DAPD will return the MC 221 with the following comment:

"Medi-Cal for this individual is based on current federal Title II/SSI disability benefits. The federal case is controlling. SSA's determination is binding until SSA revises its decision".

ii. If SP-DAPD received a referral from the CWD on a case where the federal Title II/SSI medical reexam is pending, then SP-DAPD will return the MC 221 with the following comment.

"Medi-Cal for this individual is based on current federal Title II/SSI disability benefits. The federal case is controlling. SSA is currently conducting a reexam. The CWD should verify disability status with SSA in 60-90 days."

iii. SP-DAPD initially allowed the case. Subsequently, a federal disability denial determination was made. The beneficiary has exhausted all federal appeal rights. The federal disability decision

was 12 or more months prior to SP-DAPD's reexam date.

The CWD should verify with SSA that a final disability decision was made and discontinue the case at that point. CWD will not refer the case to SP-DAPD for a reexamination because the recipient is no longer Medi-Cal eligible based on disability.

iv. Prior SP-DAPD allowances when reexam dates are due and there was a federal termination for non-disability reasons (e.g., over income limits, failure to cooperate or client's whereabouts are unknown, etc.). SSA will not perform reexams on these disability cases because client is no longer in SSA pay status.

The CWD will refer these cases to SP-DAPD as **reexam** cases. The DHS reexam cover letters sent to counties will indicate how the case should be referred.

b. SP-DAPD initially allowed disability. However, a subsequent federal disability denial determination was made. The SSA appeal is pending or it is less than 90 days since the most recent SSA denial.

SP-DAPD will not complete a reexam on these cases.

SP-DAPD will, instead, close the case as a "No Determination" and reset the medical reexam date to a future date. SP-DAPD will return the MC 221 with the annotation, "An appeal is pending on a federal Title II/SSI denial/cessation. The case remains under SSA jurisdiction. A revised reexam date has been set for _____(date). At that time, SP-DAPD will determine whether a medical reexam is necessary."

The future revised medical reexam date will be set according to the following timeframes:

i. If the SSA appeal is pending at the reconsideration level, SP-DAPD will reset the reexam for nine months from the date the reconsideration was denied. If no appeal of that decision is pending, SP-DAPD will reset the reexam for 90 days from the reconsideration decision date.

v. If the SSA appeal is pending at the Disability Hearing Unit (DHU), SP-DAPD will reset the reexam for nine months from the date the case was assigned to the DHU.

iii. If the SSA appeal is pending at the Office of Hearings and Appeals (OHA), SP-DAPD will reset the reexam for two years and three months from the date the OHA request was filed.

iv. If the SSA appeal is pending at the Appeals Council, SP-DAPD will reset the reexam for two years and three months from the date the Appeals Council review was requested.

Under 3272.2 of the State Medicaid Manual, the Centers for Medicare and Medicaid Services has directed states to do the following: "If an individual receiving Medi-Cal based upon disability is later determined by SSA not to be disabled, and the beneficiary is not eligible for Medi-Cal on some other basis, he/she is entitled to receive continued Medi-Cal eligibility if he/she timely appeals the SSA disability determination". Therefore, CWDs will continue to aid a Medi-Cal beneficiary who was approved Medi-Cal eligible due to disability and who subsequently receives a disability denial determination from SSA, if the beneficiary timely appeals the SSA denial. Once the SSA disability appeal is no longer pending, and the SSA's final decision is a denial, the CWD will discontinue the case because the recipient is no longer Medi-Cal eligible based on a disability. CWD should not refer case to SP-DAPD for a reexamination.

If SP-DAPD determines that the client is no longer disabled, SP-DAPD will annotate the MC 221 in Item 13, "Ceases to be Disabled," and return the MC 221 to the CWD. The CWD will determine whether any other Medi-Cal linkage can be established. If not, the CWD will send the client a timely discontinuance notice because he/she is no longer considered disabled within the meaning of the law. His/Her Medi-Cal benefits will be discontinued.

B. REDETERMINATIONS

This type of referral is made for a client who was previously determined disabled by SP-DAPD, who is (1) subsequently discontinued from Medi-Cal for a reason other than disability and, (2) who later reapplies after a break in aid alleging that disability continues to exist.

A limited DAPD packet **MUST** be sent on **ALL** redetermination referrals unless the following circumstances exist, in which case, a full DAPD packet must be submitted:

- The reapplication date is more than 12 months since the client was discontinued from Medi-Cal,
- No reexam date was set on the previous MC 221 approving disability,
- A reexam date is currently due or past due,
- A reexam date is unknown, or
- An improvement in the client's condition is noticed.

A copy of the prior MC 221 must be included with either a limited or a full DED packet.

Unless there is linkage other than disability, the case must be placed in pending status and not granted Medi-Cal benefits until SP-DAPD returns the case with a determination.

Upon receipt of a disability packet, SP-DAPD will check with SSA to determine whether there has been a subsequent federal SSA Title II or SSI disability determination within the past 12 months. If there has been a subsequent federal disability denial/cessation determination that is binding on the State, SP-DAPD will adopt the denial/cessation and instruct the county to refer the applicant back to SSA.

If the CWD receives a "No Determination" decision from SP-DAPD due to the above, the CWD should follow procedures specified in 22C-1(2) (A) to deny the case.

Example: SP-DAPD approved the case in January 1997 with a June 2000 reexam date. Client was discontinued in April 1999 for reasons other than disability and requests a restoration of the case in November 1999. The CWD must pend the application if there is no other linkage and submit a limited disability packet. SP-DAPD will check with SSA and if there is an SSI disability denial determination, e.g., July 1999, SP-DAPD will most likely return the case to the CWD as a "Z53" (denial due to adoption of federal (SSA) denial/cessation decision).

TYPE OF REFERRAL	WHEN USED (CRITERIA)	WHAT TO INCLUDE	ELIGIBILITY PENDING DAPD RESPONSE
Reexamination	Used when evaluation of disability needed to see if medical improvement has occurred. To be used when one of the following occurs: • DAPD has established a reexam date; • Client becomes employed; or • Other circumstances lead EW to believe condition has improved.	1. Copy of prior MC 221 (note on new MC 221 if not available); AND 2. A new MC 221 marked • "Reexamination" in Item 8; and • State reason for reexam in Item10; 3. A new MC 223 (not photocopy of old MC 223); 4. MC 220 for every medical source (plus 3 extra MC 220s which are signed and dated only); and 5. Any new medical record, if given to EW.	Eligibility continues UNLESS: • Client fails to cooperate with DAPD; • Whereabouts unknown/loss of contact; • DAPD determines client is no longer disabled and there is no other linkage; or • Another reason for discontinuance exists, e.g., excess property.
Redetermination	Used when client meets all of the following criteria: • Previously determined disabled by DAPD; • Received Medi-Cal as a disabled person; AND • Was discontinued for a reason other than disability.	A LIMITED PACKET: 1. Copy of prior MC 221 (note on new MC 221 if not available); AND 2. A new MC 221 marked • "Redetermination" in Item 8; and • "Redetermination After Break In Aid of 12 months or less" in Item 10 is required on ALL redeterminations unless full packet is required under one of the circumstances below. A FULL PACKET: 1. Copy of prior MC 221 (note on new MC 221 if not available); AND 2. New MC 221 marked "Redetermination" in Item 8; 3. MC 223; and 4. MC 220 for every medical source (plus 3 extra MC 220s signed and dated only) is required under one of the following:	Eligibility cannot be established • Until DAPD decision is received; • Unless client meets "presumptive disability" criteria; or • Until client has established linkage under another category.

TYPE OF REFERRAL	WHEN USED (CRITERIA)	WHAT TO INCLUDE	ELIGIBILITY PENDING DAPD RESPONSE
Redetermination (Continued)		• Client has been discontinued for more than 12 months; • There is no reexam date or it is unknown; • Reexam is due or past due; • Client's condition noticeably improved; • SSA claim pending; or • SSA denial determination made more than 12 months in the past.	
Reevaluation	Used when the county believes that the DAPD denial is incorrect and within 90 days of DAPD's decision. The following circumstances warrant a reevaluation: • DAPD independently reviewed claim and EW believes DAPD was unaware of medical evidence, conditions, or recent events which could affect the decision; OR • DAPD adopted an SSA denial and the client has totally new medical condition that was not previously considered by SSA and the client is not appealing SSA's decision. *(If DAPD adopted an SSA denial and the client alleges his/her condition has since deteriorated or has new medical evidence which was not previously considered, do NOT do a new disability packet. Send back to SSA to appeal if SSA's decision was made within 12 months.)	1. Copy of prior MC 221 (note on new MC 221 if not available); AND 2. A new MC 221 marked • "Reevaluation" in Item 8; and • State reason for reevaluation in Item10; 3. A new MC 223 (not photocopy of old MC 223) only if additional impairments, condition, or treatment sources are being reported; 4. MC 220 for each medical source; and 5. Any new medical records if given to EW.	Eligibility cannot be established until DAPD completes the reevaluation.

22D – DISABILITY EVALUATION DIVISION PROCEDURES

1. BACKGROUND

The Disability Evaluation Division (DED) of the State Department of Social Services is responsible for the medical determination of disability, whereas the County Welfare Department (CWD) is responsible for the non-medical portion of determining eligibility for Medi-Cal disability.

2. TWO COMPONENTS OF DED

The Federal Branches determine disability for the Social Security Administration's (SSA's) Title II program and Title XVI, the Supplemental Security Income (SSI) program.

There are two Bureaus of the State Programs (SP) Branch, one located in Los Angeles, the other in Oakland. They determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI.

3. INTAKE

Upon receipt of a disability packet sent from CWD, SP-DED will perform the following activities:

Disability Packets Received	Upon receipt, packets are reviewed for completeness. If incomplete or incorrect, SP-DED returns packet with a cover letter explaining actions needed by CWD, prior to resubmitting packet to SP-DED.
Disability Packets Accepted	If complete, packets are accepted and pertinent applicant information is entered into SP-DED's computer.
Case Assigned	Cases are assigned to a medical review team: a Disability Evaluation Analyst (DEA) and a Medical Consultant (MC), a medical doctor. The DEA/MC team assesses medical and vocational factors in disability claims.
Case Queried	Cases are queried via the SP-DED computer system to determine if there is a federal Title II or Title XVI disability claim pending. No valid federal decision available or pending claim: SP-DED processes the claim and makes an independent determination.

Valid federal decision available: SP-DED adopts the federal decision.

Pending federal claim: SP-DED assesses the status of the pending claim and either initiates development or waits to adopt the federal decision.

4. CASE PROCESSING

SP-DED develops cases to obtain all necessary medical or other relevant evidence, such as a vocational and/or social history. SP-DED performs the following activities:

Obtains Medical Evidence

Medical evidence is needed to document impairments in terms of specific signs, symptoms and laboratory findings.

Makes Client Contact

Client contact may be made to obtain additional information. Client may also be asked to go to a consultative examination paid for by the state. If contact is unsuccessful, claim may be returned to CWD for assistance in contacting client or obtaining necessary cooperation to process claim.

Applies Disability Criteria

Medical criteria for Disability are based on SSA's Listing of Impairments which contain over 100 medical conditions that would ordinarily prevent an adult from working or, for children, from performing age appropriate activities.

Assesses Vocational Factors For Adults

Vocational factors are assessed to determine client's ability to do work-related activities when a finding of disability cannot be made on medical considerations alone.

Assesses Age-Appropriate Activities For Children

When a finding of disability cannot be made on medical considerations alone, SP-DED assesses a child's ability to function independently and effectively in an age-appropriate manner.

Initiates Presumptive Disability (PD)

When a PD decision has not been made and client has a condition for which PD can be granted, SP-DED will alert the CWD and document the PD decision.

Performs Medical Deferment

Cases can be medically deferred for up to three months when future evidence is needed to assess duration and severity of an impairment.

Medical deferment is an exception to the rule, rather than a routine procedure. Common reasons are strokes or heart surgery. SP-DED will send informational form SPB 101 to CWD which provides the reason for the medical deferment.

Documents Decision

When a decision is made, it is explained on MC 221 or its attachment. The original copy is sent to CWD.

NOTE: If a decision is less than fully favorable, CWD may use the Personalized Denial Notice to explain to client the reason for the decision, but should **not** send a copy of the MC 221 or its attachment with client's Notice of Action.

Performs Reexaminations

When a reexam date arrives, CWD **must** submit cases for a medical review by SP-DED, except for decisions which were adopted from a federal claim.

Disability ends if evidence shows there is medical improvement related to the ability to work, or the ability to engage in age-appropriate activities in Disabled Child cases.